University College London Hospitals NHS Foundation Trust

University College Hospital & Elizabeth Garrett Anderson Wing

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

Summary of findings

Summary of findings

Letter from the Chief Inspector of Hospitals

University College Hospital (UCH) is a teaching district general hospital situated in the London Borough of Camden in Central London. It includes the Elizabeth Garrett Anderson Maternity Wing and is part of the University College London Hospitals NHS Foundation Trust. It has close association with University College London (UCL).

The hospital has720 in-patient beds, 12 operating theatres and houses the largest critical care unit in the NHS. The Emergency and Urgent Care department sees approximately 171000 patients per year.

UCH is a major teaching hospital and is closely associated with the UCL Medical School. It is also a major centre for medical research.

In 2015 the urology department moved to the University College Hospital site in Westmoreland Street which had formerly been the Heart Hospital.

We carried out this inspection as part of our comprehensive acute hospital inspection programme for NHS acute hospital trusts. We had earlier inspected this hospital in November 2013 but we did not at that time formally give a rating for the hospital and its core services as we were at that time still in the pilot stage of our new and current methodology.

The announced part of the inspection took place between 8-11 March 2016, and there were further unannounced inspections which took place between 18 – 25 March 2016.

Our key findings were as follows:

- Overall we rated University College Hospital as Good.
- We rated surgery, critical care, maternity and gynaecology, services for children, and outpatients and diagnostic imaging as good. We rated urgent and emergency care, and medical care as requires improvement. Because specialist palliative care is provided through a service level agreement by a third party provider we have not reported on that service.
- Overall we rated effective, caring, responsive and well- led as good and safe as requiring improvement.
- The organisation had a long-standing model of tripartite management (nursing, medical and general management), reporting to a Medical Director. The organisation had a clear vision and ambition for specialist care and research. Local services, i.e. emergency care for the local population, also featured in the Trust strategy and it was noted that capital investment had been identified to the support the development of the Emergency Department.

We saw areas of good andoutstanding practice including:

- There was outstanding local leadership in critical care with high levels of staff and patient engagement.
- In maternity and gynaecology we saw examples of outstanding world class practice, notably the One Stop first trimester Down's syndrome Screening clinic with immediate Fetal Medicine referral, the gynaecology Integrated 'One Stop' Diagnostic and Testing service, and the see and treat service in colposcopy.
- We found all staff overwhelmingly to be dedicated, caring and supportive of each other within their ward and division.
- We saw high levels of support given to staff in an innovative environment with good examples of innovation and best practice.
- Improvements had been made to the environment inthe emergency department (ED)removing patients doubling up in cubicles which had been noted in the previous inspection.
- We found patient feedback when treatment had been given to be overwhelmingly positive.
- In surgery, staff demonstrated good knowledge of reporting, investigating and learning from incidents.
- There were on-going improvements in the use of the World Health Organisation (WHO) five steps to safer surgery checklist.

Summary of findings

- We saw staff treating and caring for patients with compassion, dignity and respect.
- There was good multi-disciplinary working in surgery and a strong focus on improvement at all levels.
- In critical care there were effective systems in place to protect patients from harm.
- Safe numbers of staff cared for patients using evidence based interventions.
- Staff at all levels in critical care had a good understanding of the need for consent and systems were in place to ensure compliance with deprivation of liberty safeguards.
- In maternity and gynaecology, staff were competent in their roles with good levels of collaborative working across the service.
- In services for children, care and treatment reflected current evidence based guidelines.
- In end of life care, the specialist palliative care team were knowledgeable, skilled and highly regarded.
- In outpatients and diagnostic imaging, patients were treated with dignity and their privacy was respected.

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

- Despite improvements in the layout of the emergency department, the recent ED redesign to address the increasing demand for its services was failing to meet patient needs at the time of our inspection.
- Patients in ED experienced significant delays in initial assessment.
- Incidents in ED were going unreported due to staff pressure.
- The ED did not meet Royal College of Emergency Medicine (RCEM) recommendations that an emergency department should provide consultant presence 16 hours per day 7 days per week.
- In ED, early warning scores , sepsis screening and pain management were not being consistently recorded in patient records.
- Mandatory training targets were not being met consistently.
- Staff in ED complained that their concerns were not being listened to.
- We were not assured that the leadership of the ED were providing sufficient or timely information to trust senior management on the concerns that staff had identified in relation to the service redesign.
- In medical care, risks identified were not being recorded on risk registers.
- Documentation and patient records across medical wards was inconsistent and sometimes of poor quality.
- Patient outcomes on medical wards were variable.
- In outpatients and diagnostic imaging the trust had performed mostly worse than the England average in 2014-15 for the percentage of people seen by a specialist within 2 weeks from an urgent referral made by a GP.
- The trust also performed worse than the England average in relation to 31 and 62 day targets from referral to treatment.
- The trust performed consistently worse than the England average for diagnostic waiting times in 2014-15.

Importantly, the trust needs to:

- Examine its streaming process in ED and seek to engage ED staff in developing a system that meets the needs of patients in ED.
- Significantly reduce average time spent per patient in ED.
- Shorten the time to initial assessment of patients in ED.
- Ensure full incident reporting, investigation and learning takes place
- Examine emergency cover in ED to ensure it meets College of Emergency Medicine recommendations.
- Ensure that any risks of alleged and potential bullying are understood and ensure that the trust takes action where that bullying is known or arises.
- Ensure consistent and full recording or early warning scores, sepsis screening and pain management.
- Ensure mandatory training targets are met consistently.
- Ensure that all risks identified are noted on the risk register.
- Examine recording of patient records and ensure improvements to meet consistent best standards across all wards.

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- Examine effectiveness of treatment across medical wards to comply with national guidelines to improve patient outcomes.
- In medical care and all areas ensure that care of patients living with dementia or learning disability goes beyond mere identification and devise clear care pathways to meet the needs of these patients.
- Review the policy on admitting paediatric patients in critical care including the management of paediatric patients on the adult critical care unit to assure delivery of safe and effective care.
- Ensure all staff (including medical and nursing) working in paediatric outpatients receive and have regularly updated level 3 safeguarding training
- Make necessary improvements on patient waiting times for treatment including referrals and emergency referrals from GPs.
- Ensure improvements to diagnostic waiting times.
- Review performance against the 31 day target from diagnosis to first definitive treatment, produce and improvement action plan and monitor performance against that action plan.

The above list is not exhaustive and the trust should examine the report in detail to identify all opportunities for improvement when determining its improvement action plan.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	• Improvements had been made tothe environment in EDsince the previous inspection in November 2013. However staff were struggling to effectively cope with arecently introduced streaming system for patients. Patients experienced significant delays in initial assessment and treatment.Many staff told us that since the introduction of the new working model their concerns were not listened to. • The ED did not meet the College of Emergency Medicine (CEM) recommendation that an emergency department should provide emergency cover 16 hours a day, seven days a week. • Although staff demonstrated an open and transparent culture about incident reporting and patient safety some adverse incidents went unreported because staff did not have the time to complete an incident report. • Early Warning Scores (NEWS), sepsis screening, and pain management were not consistently recorded in patient records. • Nursing and medical staff were not meeting the trust targets for some significant mandatory training courses, including safeguarding.
Medical care (including older people's care)	Requires improvement 	• Senior staff lacked oversight of some issues within the service and risks we identified were not recorded on the relevant risk register; for example risks relating to the electronic prescription charts.Staff reported incidents, however feedback and learning from these was variable and senior staff did not complete on-going follow up of actions identified as a result of investigations. • Documentation across the wards was not completed to a satisfactory level; there were many incomplete assessment and care bundle forms and records without patient identifiable

Summary of findings

information. We also saw evidence some patients were not escalated appropriately when deteriorating and a lack of systematic identification of sepsis patients.

- Patient outcomes were variable, including more deaths than expected in some clinical areas and a higher risk of readmission for some specialties. We saw evidence of some practice which was not in line with current recommendations, and variable safety thermometer results. Additionally a number of patients were seen to be receiving oxygen therapy without a prescription.
- Patient feedback was mainly positive and we observed many positive interactions between staff and patients. However there were occasions when patient privacy and dignity was not fully maintained.

Surgery

Good

- Staff demonstrated good knowledge of the process of reporting; investigating and learning from incidents. We saw good evidence of local and trust wide learning from incidents that had occurred. There were on-going improvements in the use of the World Health Organisation (WHO) Safer Surgery checklist. Staff demonstrated that this was embedded in their practice and audit data demonstrated this was carried out to a high standard.
- We saw staff treating and caring for patients with compassion, dignity and respect. Patient feedback was positive. Patient outcomes were monitored through internal and external audits and benchmarked against other services.
- There was a strong focus on improvement from all levels of staff when results were less them optimum.There was good multidisciplinary team (MDT) working between doctors, nurses and other allied health professionals throughout patient pathways.

Critical care

Good

- There were effective systems in place to protect patients from harm and a good incident reporting culture.

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- Learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us about improvements in practice that had occurred as a result.
- Safe numbers of staff cared for patients using evidence-based interventions. There was good access to seven-day services and the unit had input from a multidisciplinary team.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- There was good local leadership on the unit and staff reflected this in their conversation with us.
- Staff and patients were engaged in decision making on the unit and provided feedback about the service.
- The unit was engaged in research a large team of nurses and doctors dedicated to the research programme.

Maternity and gynaecology

Good

- Staff were competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working in the maternity service. Staff worked collaboratively to serve the interests of women across hospital and community settings.Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.
- We saw examples of outstanding world class practice, notably the One Stop first trimester Down's syndrome Screening clinic with immediate Fetal Medicine referral, the gynaecology Integrated 'One Stop' Diagnostic and Testing service, and the see and treat service in colposcopy. Surgical management of miscarriage under local anaesthetic in the Early Pregnancy Unit and integrated multi-disciplinary working within the Fetal Medicine Unit were also examples of outstanding practice.
- Feedback from patients and those close to them was positive. Overwhelmingly we received feedback that care was excellent and

Summary of findings

compassionate. Women reported being treated with dignity, respect and kindness during all interactions and patient-staff relationships were very positive.

Services for children and young people

Good

- The service had a robust process for ensuring incidents were reported and investigated. All staff were aware of their responsibilities to report and lessons were learnt where incidents had taken place. Patient risks were appropriately identified and acted upon with clear systems to manage a deteriorating child or baby.
- Care and treatment reflected current evidence-based guidelines, standards and best practice. The services participated in a number of national and local audits to measure their effectiveness and to drive improvements. Performance against the national neonatal audit programme and the national diabetes audit was better than the national average and there was evidence of local action plans to address any issues identified.
- Pain was being effectively managed and regularly monitored. Nutrition and hydration was being monitored and dietician input was available when needed.
- Children were cared for in a caring and compassionate manner. Their privacy and dignity was maintained throughout their hospital stay. Fully trained and registered children's nurses and neonatal nurses throughout the service ensured that children and their families were informed about their care and were fully involved in any treatment decisions. Consent to care and treatment was obtained in line with legislation and guidance.

Outpatients and diagnostic imaging

Good

- There were systems for reporting incidents and raising concerns. Outcomes from these were shared with staff and used for shared learning. Records were stored securely.Risks were listed on local risk registers which were up to date and reviewed regularly.

Summary of findings

- The environment was clean and hygienic and the department was staffed adequately in order to run all of the outpatient and diagnostic imaging services.
- There were systems which allowed effective performance monitoring. There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging departments. We observed that staff worked well as a team supporting one another. Staff told us they felt able to raise concerns and discuss issues with the managers of the department.

University College Hospital & Elizabeth Garrett Anderson Wing

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to University College Hospital & Elizabeth Garrett Anderson Wing

University College Hospital (UCH) is a teaching district general hospital situated in the London Borough of Camden in Central London. It includes the Elizabeth Garrett Anderson Maternity Wing and is part of the University College London Hospitals NHS Foundation Trust. It has close association with University College London (UCL).

The hospital has 720 in-patient beds, 12 operating theatres and houses the largest critical care unit in the NHS. The Emergency and Urgent Care department sees approximately 135000 patients per year.

UCH is a major teaching hospital and is closely associated with the UCL Medical School. It is also a major centre for medical research.

In 2015 the urology department moved to the University College Hospital site in Westmoreland Street which had formerly been the Heart Hospital.

Our inspection team

The inspection was led by the Chair, Dr Edward Baker, CQC Deputy Chief Inspector and Nicola Wise, CQC Head of Hospital Inspection for North London.

Our inspection team included CQC managers, inspectors and analysts as well as consultants, doctors and nurses in emergency and urgent care, general medicine, critical care, surgery, end of life care, maternity and gynaecology, outpatients, paediatrics as well a junior doctor and student nurse. It also included allied health professionals, a safeguarding lead, senior NHS managers and experts by experience who have used NHS services. The team undertook an announced visit over 3 days from 8 to 11 March 2016 and undertook unannounced inspections following the main inspection.

How we carried out this inspection

To get to the heart of patients' experience of care in this acute trustwe always as 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?

Detailed findings

- Is it well-led?

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included local clinical commissioning groups, NHS England, Health Education England, NHS Trust Development Authority (now NHS improvement), General Medical Council, the Nursing and Midwifery Council, Royal Colleges and local Healthwatch. During the inspection we held a series of events with the intention of listening to the views of patients, their families and carers as well as members of the public about the services provided by the trust. We spoke with patients and their families and carers and members of staff from all the ward and community health areas. We reviewed records of personal care and treatment as well as trust policies and guidelines. We held focus groups of different clinical and non-clinical staff grades to gain their views. Similarly we held a focus group for black and ethnic minority staff.

Facts and data about University College Hospital & Elizabeth Garrett Anderson Wing

Key figures

• **Beds**: 812

– 716 General and acute

– 96 Critical care

• **Staff**: 7,617

– 1,396 Medical

– 2,576 Nursing

– 3,645 Other

• **Revenue**: £933,936 m

• **Full Cost:** £931,483 m

• **Surplus (deficit): £2.453m**

Activity summary (Acute)

Activity type 2014-15:

Inpatient admissions **:**170,000

Outpatient (total attendances) : 1,010,950

Accident & Emergency (attendances) : 135,000

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Good	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Good	Good	Good	Requires improvement	Requires improvement
Surgery	Good	Good	Good	Good	☆ Outstanding	Good
Critical care	Good	Good	Good	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Good	Good
Overall	Requires improvement	Good	Good	Good	Good	Good

Urgent and emergency services

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

Information about the service

The Emergency Department (ED) at University College Hospital (UCH) provides a 24-hour, seven-day a week service, and is amongst the highest attended departments in England. The ED saw approximately 131,000 patients between April 2014 and March 2015 and 87.6% of patients were 17 years old or older. Between April 2015 and August 2015 14% of ED attendances resulted in admission. The paediatric ED saw approximately 16,000 patients from April 2014 to March 2015. The ED is type 1 with a consultant-led 24 hour service and full resuscitation facilities.

The ED has seen a large year on year increase in number of ED attendances above the national average (average 5% and 2% last year) a large proportion of patients were out of area, and some were tourists.

Median monthly attendances were 23% from Camden CCG, 21% other London CCG's, 20% Islington CCG, 10% overseas visitors, 9% rest of UK, 7% Westminster, 4% Haringey, 4% City and Hackney and 3% Barnet.

The ED includes a majors department with an Acute Assessment (AAA) and Acute Care (AC) area with 18 cubicles, 1 diagnostic room, 2 waiting chair areas, a 5 bedded resuscitation area (including one designated cubicle for children), a Clinical Decision Unit (CDU) with 9 beds and four reclining chairs for patients who require on-going observation or assessment prior to discharge. In addition there is a co-located Emergency Day Unit (EDU) for ambulant and non-ambulant patients, led by the Acute Physician Team, open 1000-2200hrs weekdays, with three clinic examination rooms, 10 beds and 8 reclining chairs, for GP expected patient's and patients presenting to the Emergency Department who require specialist medical opinion.

There is an Urgent Treatment Centre for patients with minor conditions, this is comprised of 8 cubicles, 2 treatment rooms and includes co-located x ray facilities. There is a 3 bedded mental health unit based place of safety, 'the Transitional Assessment Facility' (TAF) specialist mental health medical and nursing care is provided via service level agreement with a neighbouring mental health trust. This unit was designed for patients with urgent mental health needs who are sectioned under the Mental Health Act (1983 (amended 2007)).There are separate facilities for children within the service located near the reception with 2 beds, 1 cot and 1 cubicle in the department.

The department was built in 2005 for a capacity of 65,000 patients per annum, though has since seen year on year increased attendance. To accommodate this increase the department is undergoing a series of planned renovations through to 2018. The first phase was completed in 2015 and the ED increased in size from 1626 meters squared to 2526 meters squared and now has a further 9 beds in majors.

A new model of care was introduced on the 16th of February 2016 with patients streamed depending on mode of arrival. Self-presenting patients arrive at the ED entrance on the ground floor of the hospital in the waiting room and are first seen by a receptionist. They are then seen by a streaming senior nurse or a streaming doctor who conducts an initial assessment to refer patient to an appropriate part of the department depending on the

seriousness of their condition. If the patient arrives by ambulance, they are booked into the majors area in the acute assessment unit (AAU) where an initial assessment is completed. Children book in at reception and are streamed into children's ED, located between the ED reception and the acute assessment area.This new model of care was a very new initiative introduced just prior to our inspection.

The hospital provides a number of specialist services which we did not review the pathways for during this inspection. The hospital is also a hyper acute stroke unit (HASU) for North Central London and the ED receives all acute stroke patients across that area.

We spoke with 47 patients during the inspection, 64 members of the staff including doctors in training, consultants, specialty consultants, nurses, senior nurses, advanced nurse practitioners, play specialists, reception and administrative staff and health care assistants. We looked at a total of 70 patient records.

We undertook an unannounced inspection during the evening (6pm to 10pm) of the 22 March 2016.

Summary of findings

We rated safety in the ED as requires improvement. This was because:

- Although staff demonstrated an open and transparent culture about incident reporting and patient safety some adverse incidents went unreported because staff did not have the time to complete an incident report.
- Patients experienced significant delays in initial assessment and treatment.
- Patients were not receiving sufficient screening for risks in initial assessments. Early Warning Scores (NEWS), sepsis screening, and pain management were not consistently recorded in patient records.
- Nursing and medical staff were not meeting the trust targets for some significant mandatory training courses, including safeguarding and life support.
- The ED did not meet the College of Emergency Medicine (CEM) recommendation that an emergency department should provide emergency consultant presence 16 hours a day, seven days a week.

However,

- There were robust systems in place for hand hygiene and infection control.
- Staff we spoke with understood their responsibilities regarding Duty of Candour.
- Medicines were stored securely in compliance with the trust's medicine management policy.

We rated the effectiveness of the ED at UCH as good. This was because:

- The department followed applicable national guidance and used evidence based practice when implementing treatment, care pathways and audits. Pathways for ear, nose and throat, breast cancer and fractured neck of femur were understood by staff. Pathways for children in ED have been in place since 2012.
- There were examples of the department working with other teams within and outside the hospital.

Urgent and emergency services

- Personal development reviews of staff, both nursing and medical were being completed and staff had the opportunity to access 'in house' training. Staff felt supported and told us that clinical supervision and appraisals were good.

We rated caring at the ED as good. This was because:

- Interactions between staff and patients were individual and delivered in a caring and compassionate way. Staff treated patients with dignity and respect, and were positive in nature though this was not as consistent during busier periods within the department or when patients were waiting.
- Staff involved patients and their relatives in the delivery of care and treatment and tailored their help to the individual needs of the patient.

However,

- Patients' privacy was not always supported.

We rated the responsiveness of the ED at UCH as requires improvement. This was because:

- The total time in the ED (average per patient) for the trust was higher than the national average.
- A new model for streaming patient had been introduced in the weeks before our inspection. It was not yet fully embedded or understood by staff at the time of our inspection.
- The department recognised the need to respond to the increasing demands for its services but service redesign did not yet meet patient needs caused by increased patient flow.
- ED staff were unclear if complaints within the TAF mental health facility were the responsibility of the ED department or the local mental health trust.

However,

- The trust had consistently performed better than the England average against the 4 hour waiting time target from November 2014 up to the time of our inspection.
- Patients being assessed or treated were offered tea, coffee, water and sandwiches. Charge nurses were able to order more substantial food, such as hot soup, where necessary.
- Written complaints for ED were investigated and responded to in detail and we saw that some actions were discussed.

We rated the leadership of the ED at UCH as requires improvement. This was because:

- Substantive changes had not been introduced in a way that fully engaged and prepared all staff for the implementation of a new model of care. There was a substantial division of opinion between medical staff who were in favour and nursing staff who appeared mainly opposed to this new model.
- Nursing staff satisfaction in particular was low; when staff raised concerns they said they were not listened to.
- There were some omissions and inefficiencies in risk reporting on the risk register.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement

We rated safety in the ED as requires improvement. This was because:

- Although staff demonstrated an open and transparent culture about incident reporting and patient safety some adverse incidents went unreported because staff did not have the time to complete an incident report.
- Patients experienced significant delays in initial assessment and treatment.
- Patients were not receiving sufficient screening for risks in initial assessments. Early Warning Scores (NEWS), sepsis screening, and pain management were not consistently recorded in patient records.
- Nursing and medical staff were not meeting the trust targets for some significant mandatory training courses, including safeguarding and life support.
- The ED did not meet the College of Emergency Medicine (CEM) recommendation that an emergency department should provide emergency consultant presence16 hours a day, seven days a week.

However,

- There were robust systems in place for hand hygiene and infection control.
- Staff we spoke with understood their responsibilities regarding Duty of Candour.
- Medicines were stored securely in compliance with the trust's medicine management policy.

Incidents

- The service provided available incident data reported within the last four reportable months prior to inspection (September 2015 to December 2015). 200 incidents were reported during this period, with four identified as causing moderate to severe harm to the patient. The trust provided an incident log, which described incidents and actions to address serious incidents.
- The trust reported no never events during the timeframe of available data (October 2015 to September 2015).
- Staff informed us they were encouraged by managers and colleagues to complete incident reports. They told us charge nurses spoke to all staff on shift to inform them of learning from incidents, and that incidents were discussed at morning meetings, recorded in logbooks and through informal verbal feedback.
- Staff told us they often did not have time to record the inappropriate streaming of patients, including instances where patients had to be sent back to majors after initially being sent to the urgent treatment centre (UTC). Staff escalated each concern verbally to their manager or the lead consultant, but felt nothing was done. During the inspection, staff told inspectors about three incidents in February where patients had been inappropriately streamed to the UTC before being sent to a more acute area of the ED. Some described bullying behaviours they witnessed from senior leaders when they raised these concerns, which prevented staff from speaking up.
- Staff told us they were aware of adverse event reviews in the department. The trust provided examples of the Emergency Department Clinical Governance Bulletin where learning from incidents was fed back to staff.

Duty of Candour

- The trust provided data relating to Duty of Candour disclosures in the last four months, which provided details of the incident and the service actions to address the issue. Duty of Candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with understood their responsibilities regarding Duty of Candour.

Cleanliness, infection control and hygiene

- 100% hand hygiene compliance in the service was reported by staff. Data provided by the trust on hand hygiene compliance from June 2015 to December 2015 showed every month above the target of 90%.
- 96% nursing and 89% medical staff working in the ED had received training in infection control against the trust's own target of 90%.
- Cubicles viewed by us in the acute assessment unit were clean with no high or low-level dust and curtains were clean and in date.

- We noted that all curtains in all cubicles in the UTC were changed on 8 March 2016.
- The floors and bins in the screening area were clean. Two sharps boxes had been labelled and assembled correctly. Each bay had the relevant information on walls for sepsis and advice for patients coming from a region affected by MERS or Ebola.
- The sluice area in the AAA had six sharps boxes that were all tagged and labelled. Commodes were cleaned and marked with 'I am clean' stickers.
- In the corridor area clean linen that was stacked on the trolley had not been covered, which was an infection control risk. There was also a dirty linen skip on the main corridor area.
- We observed that staff complied with the trust policies for infection prevention and control. This included wearing the correct personal protective equipment, such as gloves and aprons.
- The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand sanitising gel. The 'bare below the elbows' policy was observed by all staff.
- The trust provided the infection control scorecard, which was reviewed at the Infection Control Scorecard Quality & Safety Committee in December 2015 for information up to end of November. Two MRSA bacteraemias were reported in this timeframe against a trust benchmark of zero. Key learning points identified in the root-cause analyses of each case had been undertaken by the trust. The learning points included patients to have an assessment on admission for the presence of invasive devices which are regularly checked for signs of infection, making staff aware of which patients are colonised with MRSA, and ensuring correct prescription and administering of antibiotics.
- The Trust had identified eight possible cases of MERS (Middle East respiratory syndrome) which had triggered the MERS algorithm for the ED between October 2015 and December 2015. Four of those cases were admitted to hospital but were all negative. The team followed the MERS pathway for suspected patients. In this period, staff also received PPE (personal protective equipment) training for MERS and Ebola as part of ED Emergency Preparedness, Resilience and Response (EPRR).
- The Trust provided results of the ED antibiotic usage following concerns from the Clinical Quality Review Group (CQRG) regarding the use of broad-spectrum antibiotics and C difficile infection rates in the community. Results indicated an overall compliance rate of 32% to current UCLH guidelines. The main reasons for non-compliance included using broad-spectrum antibiotics where narrow spectrum agents would suffice and incorrect duration of treatment. Audit results were presented at the ED governance meeting and guidelines were updated to align ED antibiotic guideline with trust and local CCG antibiotic guidelines where appropriate.

Safety Thermometer

- Governance board information was displayed in the public corridor and in the reception area. Daily attendances and breaches were displayed, including the number of patients seen the day before within the expected waiting time. Performance was displayed as 90% (against a target of 90%). Hand hygiene compliance was reported as 98% (against a target of 90%). Information about levels and the staff on shift were completed on the display board.
- Results from the 'Friends and Family' test for January and February 2015 were displayed in the reception area, which reported 14 complaints and five compliments were received.

Environment and equipment

- We observed all equipment had been checked and labelled for their yearly inspection with clinical engineering.
- Records on the resuscitation ('crash') trolley in the acute assessment area stated that all equipment (suction, oxygen and defibrillator) had been checked and was working.
- The resuscitation area had five bays, one of which was a dedicated paediatric bay. Records we looked at showed the paediatric resuscitation trolley was checked daily for broken seals and the entire contents were checked weekly.

- We reviewed resuscitation equipment checklists in the resuscitation bay and found that checks were completed on 27 out of 28 days in February 2016.
- We checked an ECG machine, suction unit, cardiac monitors, syringe pumps and defibrillator machines in the resuscitation bay and found these were in working order, tested regularly by the medical engineering department and accordingly labelled.
- We observed some possible ligature risks identified in the paediatric ED clinic room. The CQC has subsequently alerted the organisation to this risk and the trust stated they have mitigation plans in place to address this.
- Records showed the resuscitation trolley in the CDU was checked 29 out of 31 days in October 2015 and 29 out of 31 days in January 2016: otherwise, all checks were completed.

Medicines

- Medicines were stored securely inside locked medicine cupboards which complied with the trust's medicine management policy.
- ED staff regularly checked controlled drugs (CD) daily.
- Medication fridges were locked and temperatures checked and recorded. Fridge temperature checks were not always completed in the resuscitation area with some checks between 1 and 21 February missing.
- In the acute assessment area we found medications and intravenous (IV) fluids were stored in a locked room.
- Triage trained staff were trained in patient group directives (PGDs) in the emergency department. There were three active PGDs for analgesia in the ED. In addition, ED had five non-medical prescribers in the nursing team on the trust non-medical prescribers register. Staff told us they had previously been issues with Patient Group Directions (PGDs) since the new streaming model had been introduced and that it had been quicker to prescribe prior to the new model. Nurses had access to the Electronic Prescribing and Administration (EPMA) to support effective administration of medicines.
- 93% of nursing staff and 83% of medical staff working in the ED had completed mandatory medicines management training against the trust's target of 90%.

Records

- A paper record was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. This was referred to as the 'CasCard'. All healthcare professionals recorded care and treatment using the same document.
- An electronic patient system ran alongside paper records and allowed staff to track patients' movement through the department and to highlight any delays.
- We reviewed patient records for completion of early warning scores. No NEWS (national early warning score) were completed for 30 adult patients and no PEWS (paediatric early warning score scores were completed in 10 paediatric patient records.
- Pain scores were recorded in six out of 10 paediatric notes we looked at. Pain scores were recorded in one out of 30 adult patient records. During the unannounced inspection, we examined an additional ten patient records, none of which had completed pain scores.
- In the 30 selected adult patient notes, no allergy information or information relating to the recording of suspected domestic violence was completed.
- The ED department had included 'CasCard' records on the risk register because the card had occasionally been misplaced when staff coded cards following discharge from the department. An ED e-casenote project to scan all ED cascards began in July 2016. A key aim of this project is to eliminate misplaced Cascards.
- 14 records were reviewed during a record keeping audit undertaken by the trust in January 2016, which showed 54% records were completed. There was no evidence of action taken to improve this.
- 88% of administrative staff, 84% of nursing staff and 65% of medical staff in the ED had completed information governance training against a trust target of 90%.

Safeguarding

- The trust provided us with records that showed variable compliance with mandatory safeguarding training for staff.

Urgent and emergency services

- 58% of medical staff and 71% of nursing staff working in the ED had received training in safeguarding vulnerable adults at level 2 against the trust's own target of 90% for staff identified as requiring the training.
- 80% of nursing staff working in the ED had received training in safeguarding vulnerable adults at level 3 against the trust's own target of 90% for staff identified as requiring the training.
- 98% of nursing and 81% of medical staff working in the ED had received training in safeguarding children at level 2 against the trust's own target of 90% for staff identified as requiring the training.
- 73% of nursing staff and 16 of 18 consultants contributing to a total of 85 of 129 staff working in the ED had received training in safeguarding children at level 3 against the trust's own target of 90% for staff identified as requiring the training
- The trust informed us that all staff in paediatric ED were required to have level 3 child safeguarding training completed. However, junior doctors were stated as being exempt from this due to rota arrangements. This meant the trust could not demonstrate they met Intercollegiate Standards for Safeguarding Children and Young People which requires all clinical staff working with children and young people to have Level 3 training.
- The electronic patient tracking system used in ED support provided additional support for safeguarding by generating proformas which could be used for escalating concerns and liaising with safeguarding colleagues.

Mandatory training

- The trust provided a training matrix of mandatory training courses completed across ED. The data provided could be broken down by discipline. Overall, emergency services had a compliance rate of 93% for completion of mandatory training across all staff.
- Nursing staff were compliant with the trust training target (90%) for inoculation incidents, conflict resolution awareness, hand hygiene, and infection control. The trust had set ambitious targets for mandatory training and the nursing staff delivered compliance in these areas. Medical staff were meeting trust targets for conflict resolution awareness and hand hygiene.
- Nursing staff did not meet the trust training target for dealing with violence and aggression (75% of staff completed this), moving and handling (75%), paediatric life support (55%), safeguarding adults (80%) and children level 3 (73%), fire safety (86%) and information governance (84%).
- Medical and dental staff in ED did not meet training targets for several significant mandatory courses, including adult life support(89%), infection control(89%), fire safety(75%), information governance(65%), and both adult level 2 (58%) and child safeguarding level 2 (81%). Records provided by the trust stated that no medical or dental staff had completed paediatric life support training.

Assessing and responding to patient risk

- A new model of care was introduced on the 16 February 2016 and since this time patients were streamed depending on mode of arrival. Self-presenting patients arrived at the ED entrance on the ground floor of the hospital in the waiting room and were first seen by a receptionist. They were then seen by a streaming senior nurse or a streaming doctor who conducted an initial assessment to refer the patient to an appropriate part of the department depending on the seriousness of their condition. Minor injury or treatment patients were streamed to UTC and more complex cases streamed to AAA. Some patients were streamed to the Clinical Decisions Unit if more specialist input was required.
- Staff told us that some patients had been inappropriately streamed to the UTC when their condition required more intensive care and this had resulted in delays to treatment for patients. Inspectors observed one example of a patient losing consciousness in the UTC resulting in being transferred to a resuscitation bay.
- Emergency services did not have an operational sepsis pathway for patients, and sepsis screening was not routinely carried out by staff or recorded in the patient records. Senior staff told us that a new sepsis initiative was being launched later in 2016 (UCLH Sepsis) within the department, however there was no evidence of a current system in place. On the unannounced visit, the inspection team noted two patients admitted to the acute assessment area that had not had a sepsis screening tool completed in their patient notes. The

team were also informed by staff that a patient with sepsis had been inappropriately streamed to UTC the previous day, and was transferred to resuscitation when their condition worsened.

- Inspectors looked at patient records for completion of an initial assessment within 15 minutes of arriving at ED. OF ten adult ED patient records reviewed, two of the ten recorded an initial assessment within 15 minutes of arriving. Seven out of ten paediatric ED patient records we looked at recorded an assessment within 15 minutes of arriving. This meant that some patients waited greater than fifteen minutes before receiving an initial assessment.
- The median time to treatment for patients was between 70 and 90 minutes. This meant the trust exceeded national guidelines of 60 minutes time to treatment in the year up to September 2015. This was worse than the England average which was below 60 minutes.
- The median time to initial assessment for patients arriving by ambulance was between 6 and 14 minutes, which was worse than the England median of between 4 and 6 minutes in the year up to April 2015 although the trend was one of improvement.
- In the 12 months up to March 2015, there were 420 occasions when an ambulance waited over 30 minutes to hand over a patient to the ED, which was significantly better than other trusts nationally.
- Inspectors looked at patient records for completion of early warning scores. No NEWS scores were completed in the CasCard for 30 adult patients, and no PEWS scores were completed in 10 paediatric patient records. Information on sepsis and pain was also not completed in patient records.
- The trust informed us they did not routinely undertake NEWS audits in the ED “due to the high nurse & doctor patient ratio, rather like Intensive Care”, but conducted general documentation audits in the ED.
- 96% of nursing staff and 89% of medical staff working in the ED had received training in basic adult life support against a trust target of 90%. 85% of nursing staff and 84% of medical staff working in the ED had received classroom training in adult life support against a trust target of 90%.
- 55% of nursing staff working in the ED had received training in paediatric life support against a trust target of 90%. Information provided by the trust showed 64% medical staff had completed the course.

Nursing staffing

- Information from the trust showed a planned nurse to patient ratio of 1:4 during the day and 1:7 during the night.
- From establishment data provided by the Trust there was 6773.5 required hours for nursing in December 2015. The number of rostered hours recorded in this time period was 4837.5, supplemented by 1,108.3 hours completed by bank or agency staff. This resulted in a shortfall of 827.7 hours (or 12% of all hours for December.) The respective percentage shortfall was 14% in November, 11% in October, and 25% in September. Nursing hours were supplemented by increased nursing assistant hours in three of the four months.
- Agency and bank staff usage from December 2015 was 18%. Over the previous four month period, usage of temporary staff was highest in October, reaching 21%. The Trust stated that higher use of temporary staff (18-21% against a RN vacancy rate of 12.5%) was a leadership decision to increase the nursing workforce to maintain patient safety and compensate for high levels of Emergency Department attendances during that time. However, notes on the log of required hours within ED for December 2015 noted, “Vacancies continue to drive reliance on temporary staffing". Information provided by the trust showed the nurse vacancy rate at the time of inspection in ED was 12.5%.
- There were two children’s nurses and one adult nurse during the day shift and two children’s nurses and one adult nurse at night in paediatric ED. At the time of inspection paediatric ED had two band 5 vacancies and one band 6 vacancy. Staff told us there were not always two children’s nurses on duty at night and that vacancies for paediatric trained ED nurses were difficult to fill due to a national shortage.
- Paediatric nursing staff stated that they could be “pulled across” to the adult side of ED and this allowed paediatric staff to keep their emergency department competencies up to date, including for resuscitation. The trust stated that while there were a number of dual trained nurses in paediatric ED who can be asked to

staff the main ED department to maintain their adult skills and if patient acuity is high, this would not include asking specialist paediatric nurses to work in the adult ED.

- There were two morning nursing shift start times – 8am and 10am, and staff were flexed up and down as activity dictated (more staff started at 10am as the department became busier). Some nurses told us they did not feel understaffed between 8am and 10am as there was not enough activity to warrant excess staff.
- Information provided by the trust showed the rate of absence due to sickness among nursing staff in the ED was 2.6% for the financial year ending March 2015.
- Information provided by the trust showed the rate of turnover among nursing staff in the ED was 23.1%.

Medical staffing

- The Emergency Department provided 16 hours consultant presence from 8am to 12midnight on weekdays and 14.5 hours Saturday and Sunday. The College of Emergency Medicine (CEM) recommends an emergency department should provide emergency cover 16 hours a day, 7 days a week.
- There was a minimum of five consultants covering each day over the weekdays and three consultants covering the weekend days.There was also a consultant on-call from midnight on weekdays and 8pm at weekends.
- There were 27 junior doctors covering the 24 hour period; 19 between 08:00-20:00 and 8 from 20:00 – 08:00; this includes x 2 ST4 overnight with access to the on-call consultant. In addition there were 2/3 GPs during the day 10:00-22:00 and 9 hours cover at weekends.
- All consultants in the ED had paediatric training and validated paediatric competencies.
- The paediatric ED was led by an emergency medicine consultant with a dual accreditation in paediatric emergencies. The paediatric ED was staffed by a paediatric emergency medicine consultant and emergency medicine doctors.
- There was a weekly handover with the paediatric wards to share information. This was attended by medical and nursing staff. Staff also had a daily morning handover at 8am and an evening handover from night staff coming on shift.
- In the Urgent Treatment Centre there were four medical staff rostered onto each shift. The area was staffed by one named consultant and three doctors in training. This area of the ED Department was open 24/7.
- Medical shifts were between 8-10 hours, with occasional 12 hour night shifts. There are a higher number of 12 hour shifts at weekends; however the frequency of staff being required to do these shifts is low.
- Information provided by the trust showed the medical vacancy rate in the ED was 10.3%.
- Information provided by the trust showed the rate of absence due to sickness among medical staff in the ED was 0.5% for the financial year ending March 2015.
- Information provided by the trust showed the rate of turnover among medical staff in the ED was 5.6%.

Major incident awareness and training

- The trust had a department lead within ED for major incident awareness, and a full plan was in place for escalation in the event of escalation of demand and resources. The policy had clearly defined criteria, had been ratified by the trust, and was published in February 2016.
- Major incident training was the most recent topic for discussion at the “10 for 10”: a meeting where staff reviewed themes and issues for ten minutes before the start of the 10am shift and handover
- At the time of our inspection, none of the medical staff within ED, apart from the Clinical Lead, had full major incident training. The former matron for ED was the emergency planning officer. Inspectors saw evidence of nine upcoming training days with allocated names and there is a robust system in place for arranging and logging training compliance. The department planned to have 100% of staff trained in major incidents by October 2016.
- The emergency planning lead delivered and managed training for major incidents, supported by nurses and healthcare assistants in delivery. Training included the use of a decontamination tent, putting on decontamination suits (HAZMAT), going through the policy and rehearsing roles for each staff member.

Urgent and emergency services

- A major incident equipment kit was checked by the inspection team emergency planning lead. Suitable equipment was available including VFH and MERS packs.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good

We rated the effectiveness of the ED at UCH as requires improvement. This was because:

- There was recognition that improvement following audits was required. However these were not in practice at the time of our inspection, particularly regarding pain management and the management of sepsis.
- Pain scores in the department were not completed routinely and pain was not managed effectively whilst patients were waiting for treatment.
- We found consent, mental capacity and deprivation of liberty safeguards not always taken into consideration both in practice and when documentation was being completed, particularly for patients presenting with a mental health concern.
- Emergency services had not addressed issues in the sepsis pathway for new admissions, despite poor performance in a national audit two years ago.
- Action plans developed from some audits were not always being implemented.

However,

- The department followed applicable national guidance and used evidence based practice when implementing treatment, care pathways and audits. Pathways for ear, nose and throat, breast cancer and fractured neck of femur were understood by staff. Pathways for children in ED have been in place since 2012.
- There were examples of the department working with other teams within and outside the hospital.
- Personal development reviews of staff, both nursing and medical were being completed and staff had the opportunity to access 'in house' training. Staff felt supported and told us that clinical supervision and appraisals were good.

Evidence-based care and treatment

- We were told and we observed that the service was using National Institute for Clinical Excellence (NICE) and Royal College of Emergency Medicine (RCEM) guidelines on a regular basis when developing and implementing care audits and pathways.
- The service had numerous pathways available for staff to follow when needed. Staff told us that these proformas were easy to access to add to patient's notes.
- Examples of evidence based audits and care pathways being completed included the fitting child, renal colic, asthma in children and sepsis.
- Senior staff told us the paediatric unit was meeting Royal College of Paediatrics and Child Health standards.
- We observed neck of femur (NOF) seen within protocol, ear, nose and throat (ENT) seen within protocol, breast cancer seen within protocol and plastics referred to the Royal Free within protocol.
- A local audit conducted in the children's ED identified improvement throughout the responses given by parent and/or patient. Results of the audits stated that these improved results were due to developments in the department over the past two years which included the creation of an initial assessment room in the children's ED waiting area, a dedicated team of paediatric trained nurses working 24/7 in the ED, the appointment of a lead paediatric nurse for the department and upgraded design in the department.

Pain relief

- We reviewed 50 sets of patient records and found pain assessments and scores were documented in 10 cases during streaming. This indicated that pain was not being managed effectively in the department nor followed up appropriately. Despite this, medication charts showed that staff noted when analgesia had been offered and whether the patient had accepted or declined this. On the unannounced inspection, we reviewed a further ten sets of patient notes, and found pain management continued to be unrecorded.
- Staff told us that patients that self-presented to the department had access to analgesia on request. The trust performed better than other trusts nationally in the 2014 A&E survey question relating to the waiting time for analgesia after requesting it.

- Four patients we spoke with told us their pain was managed promptly. Three patients spoken with on the unannounced inspection were not offered an analgesia following streaming to the Urgent Treatment Centre (UTC), which could mean a significant delay before being offered pain relief.
- Patients were asked to identify the severity of pain on an initial registration form only once they were streamed. Patients regularly experienced waits in reception of up to 30 minutes or longer before being asked about their pain.
- When patients were moved within the department, records showed they were reassessed for pain. The need for pain relief in the UTC was assessed by an advanced nurse practitioner.
- Actions stated in a paediatric pain audit undertaken in December 2014 included the need to amend the ED clinical proforma to simplify recording of pain score, nursing education on pain scores, and advertising in department of importance of pain control and scoring. None of these actions were implemented at the time of our inspection.
- The trust pain team was formed in January 2016 and aimed to support ED. They provided expert support and advice to offer patients even better pain relief and strategies, prevent unnecessary admissions due to exacerbations of chronic pain and redirect patients to appropriate services in a timely manner. This work had yet to commence. Staff we spoke with were not familiar with the pain team.

Nutrition and hydration

- The department used a 'MUST' (malnutrition universal screening tool) as part of individual patient assessment. This was to help identify patients that are underweight and at risk of malnutrition.
- The trust performed about the same as other trusts nationally in the 2014 A&E survey question relating to patients' ability to get suitable food and drinks while in the department.
- A water fountain was available in the reception area. We observed that reception staff were unable to leave their desks to assist two patients with limited mobility who wanted water.

Patient outcomes

- In a 2013/14 audit of severe sepsis and septic shock, the trust performed lower than the RCEM key indicator requirements. In 23% of cases high flow oxygen was administered within the ED and 43% of patient's vital signs measured and recorded in the ED notes, compared to the required standard of 100%. The requirement that 50% of patients were administered antibiotics in the ED within one hour was not achieved as the department provided this in 43% of cases. The first intravenous crystalloid fluid bolus was given in the ED within one hour in 14% of cases, compared to the RCEM standard of 75%. In 54% of cases, there was evidence in the notes that blood cultures were obtained within the ED, compared to the 100% standard.
- There was good performance in the RCEM paracetamol overdose audit 2013/14. 10% of patients who required plasma level tests received them earlier than four hours after ingestion, which was significantly better than the national average and treatments complied with the Medicines Health Regulatory Authority (MRHA) guidelines.
- Performance in the RCEM audit of asthma in children 2013/14 was "between upper and lower England Quartiles" in all measures.
- Children's ED audits were completed in safeguarding checks, pain management, asthma and fever in children under five years old.
- A 2015 RCEM audit of the consultant sign-off of patients with non-traumatic chest pain had improved from less than 40% in 2014 to 71%.
- There was mixed performance in the RCEM audit of mental health in the ED 2014/15. The trust failed to meet one fundamental standard, regarding risk assessment taken and recorded in the patient's clinical record.
- There was mixed performance in the RCEM Initial management of the fitting child audit 2014/15.
- There was mixed performance in the RCEM audit of assessment of cognitive impairment in older people in 2014/15. The trust failed to meet the fundamental standard (documentation of early warning score).

Urgent and emergency services

- In the 12 months up to July 2015 the unplanned re-attendance rate to the ED within seven days was (6.3%– 7.9%), was which generally better than the England average (7.1% - 7.8%) although did not meet the RCEM standard (5%).

Competent staff

- Records provided by the trust showed 100% of nursing staff had their appraisals completed against a trust target for of 95%. 95% of staff of other functions including administrators had received supervisions and appraisals at appropriate intervals. Records indicated 90% of doctors completed their appraisals.
- Medical staff undertook essential courses in triage, acute oncology and a paediatric study week as well as mandatory training. Doctors in training had designated teaching time and doctor led teaching sessions.
- Six doctors had been revalidated so far for 2015/2016.
- Nurses below matron level had structured developmental pathways that included periods of mentorship and observation in clinical competencies such as IV therapy and phlebotomy. The pathways were used to support staff in their development and to ensure they were competent before progressing to a higher grade. This was supported by the ED clinical practice facilitator.
- There were development programmes in place for senior nurses, employed at bands 6 and 7. They had a monthly team meeting and quarterly away days. Band 6 nurses had access to a development programme and mentorship scheme.
- Less experienced or junior nurses at band 5 were mentored by senior band 7 colleagues. Band 5 nurses told us development programmes were only open to senior nursing staff.
- We saw evidence that agency staff received an induction. For example, records showed that 35 agency nurses from one agency had completed their induction.
- There were advanced nurse practitioners in the UTC and at the main entrance to stream patients who waited in the reception area
- Charge nurses had completed training in triaging patients, though some staff reported they did not understand the streaming process within the new model.

Multidisciplinary working

- Twice daily handovers were attended by nursing, medical and management staff.
- A number of specialty teams were accessible to staff including specialist services, mental health support and drug and alcohol treatment services.
- The ED also worked with local police departments to identify when police presence was required.
- Staff in the Emergency Day Unit (EDU) used established protocols to treat and transfer patients such as referral pathways to cardiology and general medicine. Similar protocols were in place for patients about to be discharged to ensure follow ups were arranged, such as to a GP or a rapid access chest pain clinic which was run twice a week at the hospital.
- Staff told us they felt part of the team and were valued by nursing staff.
- ED staff worked well with paramedics who brought in patients, asking their opinion and taking part in a detailed handover.
- Play specialists were available in the children's ED between Monday and Friday, 9am to 5pm. They worked closely with the paediatric ward and helped to reduce anxiety in children, such as through the use of effective distraction techniques.
- During the week a Child and Adolescent Mental Health Service (CAMHS) assessment was done by one of the five paediatric consultants but out of hours a registrar undertook this role and was not always able to make a physical assessment easily, covering a high volume of patients. Staff told us CAMHS was difficult to access at the weekend. Patients that were admitted were sent to ward T12. There was no dedicated area within the ED to safely manage young people who were agitated.
- GPs were included on the clinical rota to support the UTC.

Urgent and emergency services

Seven-day services

- The ED reception, AAA, CDU, UTC and children's ED were open 24 hours a day, every day. There was a paediatric bay in the main resuscitation area which was accessible 24
- There was a 24 hour radiology service within the department which included the provision of x-ray facilities and emergency scanning equipment. CT and MRI scanning services were located in a different area but were available 24 hours when required.

Access to information

- An electronic system to track patients in the ED was used throughout the department. Staff throughout the department including receptionists, nursing and medical staff had readily available access to IT terminals throughout the department. This enabled access to patient records, assessments and treatment plans. Alongside this were paper notes of a patient's episode of care.
- The system provided support for safeguarding and patient assessment through proformas which were included as part of the system.
- Clinical staff used electronic patient records to access information from other departments in the hospital if they had been treated elsewhere. The results of the blood tests and other diagnostic results were also available using electronic patient records, which we saw staff had immediate access to.
- Staff had access to information across the patient's history in their records that would assist them with managing people who demonstrated behaviour that was challenging to staff.
- Casualty cards were noted on the ED risk register as after a patient was discharged they the card sometimes went missing.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was an up to date policy regarding consent, mental capacity and deprivation of liberty safeguards which was accessible to staff on the intranet.
- Consent forms were available for people with parental responsibility to consent on behalf of children.
- We observed ED staff obtaining consent from patients before procedures or tests were undertaken, including the recording of verbal consent.
- ED staff we spoke with had knowledge of the principles of consent and mental capacity, including the care and treatment of patients with a Deprivation of Liberty Safeguards (DoLS) order.

Are urgent and emergency services caring?

Good

We rated the caring in the ED at UCH as good. This was because:

- Interactions between staff and patients were individual and delivered in a caring and compassionate way. Staff treated patients with dignity and respect, and were positive in nature though this was not as consistent during busier periods within the department or when patients were waiting.
- Staff involved patients and their relatives in the delivery of care and treatment and tailored their help to the individual needs of the patient.

However:

- Patients' privacy was not always supported with some discussion about patients able to be overheard.

Compassionate care

- We saw that staff were caring and demonstrated compassion towards patients in one to one interactions. In quieter periods, we observed nurses and doctors welcome patients who were distressed into the acute assessment area (AAA) calmly and by introducing themselves. We also saw other examples of similarly positive interactions elsewhere in the department. One patient told us that they were very happy with how staff engaged them and said, "staff have been very nice to me."
- We saw that staff maintained the privacy and dignity of patients including the use of curtains in treatment and assessment bays and holding confidential discussions in quiet tones.
- A parent in the children's ED said, "The nurses have been very helpful so far."

Urgent and emergency services

- Patients and visitors had contributed to the national Friends and Family Test (FFT), the results of which were better than the England and London average in the year to our inspection. An overall average of 95% of respondents stated that they would recommend the department compared with a national average of 87%. The majority of people who would recommend the ED said that they were 'extremely likely' to do so.
- Responses from the A&E CQC survey 2014 demonstrated the department performed at a level equivalent to or better than similar services.
- However, during busier periods this was not demonstrated consistently by all staff. For instance, we observed reception staff failing to acknowledge patients who were waiting at the front of the reception queue for periods of over 5 minutes.
- Some patients told us that although staff interactions were positive, they felt care was not always compassionate when they were waiting. One told us, “it’s been two hours since I had my last pain medication, I don’t know what’s going on. I’ve been waiting ages for a doctor to figure out if I can have some more.” Another patient told us “I’ve used the call bell and waited over a few minutes but I’ve never gotten a reply.”
- The inspection team noted that discussions about patients could be overheard from the waiting area for acute assessment.
- We observed curtains were routinely left open during consultation in the streaming bays; this did not support the privacy of patients as the cubicles were adjacent to a corridor used by staff.

Understanding and involvement of patients and those close to them

- Staff were observed to involve patients in their care and treatment and tailored their help to meet individual needs.
- In the A&E CQC survey 2014 patients’ gave the department a score of 7.6 out of 10 for giving family or those close to them the opportunity to talk to a doctor.
- A named nurse for each patient was included on the white board above their beds so that family or those close to them were able to gain information from staff involved in the care of the patient.
- We observed a family member asking for information and the named nurse came in a timely manner to assist in providing advice.
- A patient told us they were happy with how staff had involved them in their care and said, “I need a special machine to get a needle in and they arranged it all, they have been very good.”
- Feedback from the Friends and Family Test included “feedback given in a clear, easy-to-understand way.”
- A high proportion of patients using the service did not live within the local area, and some were tourists. We saw staff explain to patients who were discharged from the ED how information about their episode of care would be shared with their GP. We also saw reception staff signpost patients who were not registered with a GP, including tourists, to how to complete relevant documentation.
- We observed staff who told patients the general timeframe for being assessed, admitted or discharged. Some patients told us this helped to alleviate anxiety that patients might have over the time they would spend there. However, we observed that this did not happen for patients in the UTC particularly during busy periods.

Emotional support

- We observed staff providing reassurance and comfort to patients. Staff took time to understand the needs of the patients to enable them to best address their concerns. We observed staff taking a detailed history from a patient to ensure they fully understood their circumstances.
- Play specialists were available in the children’s ED between Monday and Friday, 9am to 5pm. They worked closely with the paediatric ward and helped to reduce anxiety in children, such as through the use of effective distraction techniques.

Urgent and emergency services

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

We rated the responsiveness of the ED at UCH as requires improvement. This was because:

- The total time in the ED (average per patient) for the trust was higher than the national average.
- A new model for streaming patient had been introduced in the weeks before our inspection. It was not yet fully embedded or understood by staff at the time of our inspection.
- The department recognised the need to respond to the increasing demands for its services but service redesign did not yet meet patient needs caused by increased patient flow.
- Staff were unclear if complaints within the TAF mental health facility were the responsibility of the ED department or the local mental health trust.

However:

- The trust had consistently performed better than the England average against the 4 hour waiting time target from November 2014 up to the time of our inspection.
- Patients being assessed or treated were offered tea, coffee, water and sandwiches. Charge nurses were able to order more substantial food, such as hot soup, where necessary.
- Written complaints for ED were investigated and responded to in detail and we saw that some actions were discussed.

Service planning and delivery to meet the needs of local people

- ED staff were familiar with some information regarding the demographics of the people that used the service.
- There were established links with social care providers, though fewer than 20% of patients accessing the ED received support from these services.
- The location of the service meant that the demographic of the population needs were unique when compared nationally. There were a high number of self-presenters or "walk in" attendances, which totalled ranged between 350-400 on the busiest days.
- Over 60% of patients that self-presented required treatment for primary care needs or 'minor' injuries or illnesses rather than 'major' or emergency services. Simultaneously, senior leaders told us there was also a high acuity of patients in ED which meant the resuscitation department was busy.
- Concerns were also expressed by the clinical directors regarding the number of patients who were awaiting discharge, though the conversion rate of assessment to admission was one of the lowest in the country at approximately 10%. Staff experienced difficulty with the 'exit block' in getting patients in ED to an inpatient bed. Senior leaders identified that this required staff to work closely with CCGs to signpost patients more effectively to the services within primary care in the first instance.
- The new model of working introduced in the department recognised the enhanced need for general practitioners (GPs) in streaming patients and to staff the UTC. It was too early to assess whether the deployment of GPs in new model was sufficient to meet the needs of people to be appropriately referred.
- The ED served a local population of homeless people and had established referral pathways with the local authority crisis team and the drug and alcohol liaison team to address the attendance rates of this population.
- Domestic violence outreach workers were also available to the ED. Access to such specialist teams meant that staff could provide additional support above and beyond emergency medical treatment.

Meeting people's individual needs

- Information for patients visiting the department was available. Current waiting times were displayed on television screens in the main reception and UTC waiting areas.
- More patients began to visit the ED in the afternoon and evening of the inspections. At this point the waiting area

became crowded with few available chairs for patients. A similar problem was noted in UTC and AAA. During the unannounced visit, patients in the UTC and AAA waiting areas were also frequently standing.

- The paediatric unit was crowded. Parents and carers had to leave pushchairs in an area near the main ED reception area as there was insufficient space in the unit, which created further crowding in the corridor outside the paediatric unit. There were no toilet facilities in this area, meaning children had to use the nearest available bathroom within the wider ED department.
- In the paediatric unit there was a 1.5 whole time equivalent (WTE) play specialist team.
- A pathway was in place to provide appropriate treatment and referrals for patients living with dementia. Purple wristbands were used to identify these patients, and details were noted on the patient's casualty card. However, this information was not recorded on the electronic record keeping system.
- Dementia training had taken place but some staff told us that they were taken off the training due to operational pressure. Staff told us they were understaffed to look after dementia patients. There was a dedicated nurse consultant for dementia, with a team of two Band 7 specialist nurses who supported the Emergency Department Monday to Friday between 9am and 5pm. Though specialist training was provided to other groups of staff, we were told medical staff did not receive dementia training.
- There was support for staff across the hospital from a learning disability nurse specialist to provide best practice for care for patients with learning disabilities, though several staff we spoke with were not aware of this. This information was recorded on the casualty card though not shared on other systems used by staff.
- Staff were able to request visits from domestic violence teams who provided one-to-one support to people who needed assistance in and attended psychosocial meetings with mental health specialists when required. However, we noted the domestic violence section of the records was not being completed.
- Mobile phone charging facilities to better enable patients to contact their loved ones when they were admitted to the ED were implemented permanently from January 2016.
- Staff in the paediatric unit spoke of the difficulties maintaining patient confidentiality due to lack of space in the unit.
- TAF was commissioned and provided under a service level agreement (SLA) by a third party mental health trust provider as a hospital based place of safety, for patients detained under section 136 of the Mental Health Act (1983 (amended 2007)). Others were referred there after they self presented. TAF was staffed by a mental health worker and a doctor provided by the mental health trust. In addition, the trust provided a designated registered mental health nurse (RMN), a post which had been established and filled by UCH since February 2016 and two security guards from the UCLH bank who have received training to manage challenging presentations. Senior managers and staff told us there was a shortage of mental health beds in the wider community and hence patients sometimes had to stay for considerable lengths of time which might include overnight.
- End of life care plans proformas were available in ED though some staff we spoke with were not familiar with them.
- The paediatric bay in the resuscitation area was sometimes used for adults when other beds were in use. Staff told us that when this happened there was a delay to treatment as adults had to be moved from the bay to make room for the sick child.
- Staff told us that they were able to request timely support from language specific interpreters when required.
- There were no facilities for breastfeeding mothers in the paediatric unit.
- Patients being assessed or treated were offered tea, coffee, water and sandwiches. Charge nurses were able to order more substantial food, such as hot soup, where necessary.
- Patients who were awaiting secondary assessment who experienced long waiting hours could request and were offered food and drink. One patient told us, "I was given coffee whilst I was waiting there."

- There were 3 reportable mixed sex breaches due to faults with the toilets during our inspection. Staff told us this happened infrequently.

Access and flow

- The new model for streaming patient had been introduced in the weeks before our inspection. It was not yet fully embedded and understood by staff.
- A charge nurse we spoke with told us the streaming process was designed to fast track patients to the right place from reception to UTC, a GP or majors. Triaging was done after streaming.
- Staff told us that the front door rapid assessment and treatment (FRAT) role was difficult to do properly with the new screening model. Nursing staff said that they were having to screen more patients than before. They told us that this meant delays in treatment.
- We noticed that an escalation process was used when five patients were in a queue waiting to be seen, which included the redeployment of a nurse from the main ED to the streaming area to help with initial assessments.
- Although patients could be referred to a local GP practice, we were told by staff that there was no electronic record or tracking of this information.
- During the winter of 2013/2014, there was a high number of ambulance delays of over 60 minutes. This number had reduced in the winter of 2014/2015 due to the redirection of traffic and ambulance drop off area. The trust report no delays over 60 minutes between January 2015 and August 2015, however these delays had since increased with 21 reported between September 2015 and December 2015 (11 of which were in December). The trust reported that this had been due to no available space in majors or resuscitation when the ambulance arrived.
- Staff told us that patients were moved from the acute assessment unit to the CDU if they had to stay overnight in the department and some told us that CDU had improved on inappropriate admissions.
- Between November 2014 and August 2015 the trust was mostly meeting or above the standard to see, treat and discharge 95% patients within 4 hours. The trust had consistently performed better than the England average against this target since November 2014 to the time of our inspection. Between September 2015 to November 2015 performance was between 90 and 95%. The recent trend has been downward with an average 90% for five consecutive months prior to our inspection, but continues above the England average.
- The total time in ED (average per patient) for the trust was higher than the national average. In the 12 months up to September 2015, patients spent an average 140 and 175 minutes in the department .The national average for the same period was less than 140 minutes.
- Over a 24 hour period between 8 and 9 March 2016 there were 43 breaches of the four hour target out of 441 patients. 90% of patients were seen in 4 hours. Though 10 breaches were due to lack of beds. We saw escalation to medical and surgical teams were done. There were 72 LAS arrivals. Streaming within 15 minutes had a 35% success rate and 30 minutes a 39% success rate.
- The percentage of emergency admissions waiting four to 12 hours from the decision to admit until being admitted was similar to the England average between August 2014 and November 2015.
- Meetings to discuss patients waiting over four hours and in the department over 12 hours were held daily. Staff identified breaches from the previous 24-hour period. Delays had been caused by the lack of medical beds available for patients who needed to be admitted.
- Daily bed capacity meetings were held four times a day and involved ED managers and charge nurses to discuss patients requiring admission and update on capacity predictions for the night.
- The percentage of patients who leave the department before being seen is recognised by the Department of Health as potentially being an indicator that patients are dissatisfied with the length of time they are having to wait. The trust fluctuated around the England average between July 2013 and September 2015.
- There were direct GP referrals to paediatrics for patients under one year or with known complex conditions.

Learning from complaints and concerns

- The trust's framework for complaints was used in ED when they were received, and the complaints policy was available to staff on the trust intranet. Staff we spoke with told us they would escalate to the senior nurse in charge if they received a complaint.
- Written complaints were investigated and responded to in detail and we saw that some actions were discussed.

For example, following a complaint from a patient who had experienced a failure to diagnose a serious condition (cauda equina), a full response was shared, the complaint was reviewed in the monthly clinical governance meeting and an action for all ED staff to protect patient dignity and to undertake a pain audit was stated.

- In another complaint response it was identified that staff had difficulties in obtained a bladder scanner. Lessons stated that the need for an extra scanner was to be put on risk register, though this was not evidently completed and we found staff had continued to struggle to access key equipment.
- Senior managers told us there were a small number of complaints about reception staff received regarding communication. Since then were more substantive reception staff in post since January and the trust anticipated the number of complaints would decrease.
- Staff were unclear if complaints within the TAF area were the responsibility of the ED department or CANDI.

Are urgent and emergency services well-led?

Requires improvement

We rated the leadership of the ED at UCH as requires improvement. This was because:

- Substantive changes had not been introduced in a way that made staff feel fully engaged and prepared for the implementation of a new model of care. There was a substantial division of opinion between medical staff who were in favour and nursing staff who appeared mainly opposed to this new model.
- Nursing staff satisfaction in particular was low; when staff raised concerns they said they were not listened to.
- There were some omissions and inefficiencies in risk reporting on the risk register.

Vision and strategy for this service

- A paper to the urgent care board in January 2016 regarding the ED pathway identified significant inefficiencies and delays to the patient's journey, despite the relatively good staffing numbers and multiple attempts of improvement.
- Following findings of our last inspection in November 2013 regarding the leadership in the department, failure to act on recommendations from other external reviews and the cramped space, the vision and strategy was revised. While some changes had been made, we found the pace of progress since the last inspection was slow and although required actions were addressed in a timely fashion, other findings were slower to change. A new model of care was established on 16 February 2016, despite a previous report stating this was resulting in significant delay in addressing other actions required.
- There was an articulated vision for the ED at UCH that received commitment from the trust board, local commissioners and Monitor, and focused on developing the service to meet the year on year increases in attendances. The strategy to deliver this vision required significant investment to expand the size of the department, which was well recognised and identified in our last inspection in November 2013.
- Leaders in ED told us that the model of care had needed to change for many years as the department experienced a significant challenge in coping with the high number of patients attending, combined with an increasing exit block out of ED. Plans to introduce a new model of care received support and sign off from a committee responsible to the trust board in November 2015 and was introduced on16 February 2016, two weeks before our inspection. The model was set up to use skills appropriately, acknowledging that consultants or senior doctors were not best utilised in streaming.
- Leaders told us that changes in 2015 included a recovery to achieve the 95% 4 hour performance target, redirected ambulance traffic, upgraded majors and increased capacity and commissioner approved revised pathways.
- Despite the approval from trust leaders and stakeholders, the implementation of the vision caused confusion amongst staff and had caused a rift between doctors and nurses. Many nurses felt there was a failure to adequately consult and train staff to deliver safe care under the new model. Several doctors we spoke with saw the benefits in the new secondary assessment model, though acknowledged the burden on nursing staff in streaming and in AAU and that overall it was 'easier for doctors than nurses.

Urgent and emergency services

Governance, risk management and quality measurement

- Structures to maintain working governance and risk management existed and divisional leaders understood these systems within the department. They included policies, procedures and strategies for staff, incident reporting systems, opportunities to formally share learning across staffing groups and grades in the ED meetings and committees' structure to senior leaders via the urgent care board, involvement in national clinical audit programmes and monitoring national quality targets such as the 4 hour waiting time. Senior leaders also told us of the on-going productive ED programme, whereby staff met monthly to review the quality of the service.
- Senior clinicians met regularly with the management team and we saw that governance, risk management and aspects of quality were discussed in specific forums. These included the ED risk management subcommittee which had been recently introduced, safety rounds, daily quality huddles, care quality improvement rounds and paediatric and adult ED regular joint meetings. Two ED consultant doctors were named as leads for quality and safety. Some staff also told us that certain meetings, including '10 for 10', which was to capture safety risks, were only introduced a few days prior to the inspection and we saw staff were unaware that they should attend and visibly unsure of what they were expected to discuss.
- When we met with senior leaders they told us the biggest risks were overcrowding compromising patient safety, staff burnout and patient satisfaction.
- The risk register submitted at the time of our inspection was described as the most recent iteration. There were eight risks identified on the risk register, though these did not capture all the risks pertaining to the ED such as the concerns staff had raised regarding the risks of the new working model. Of the eight risks featured, three had not been updated for several to over 6 months, four were not reviewed at regular frequency, for three risks the accountable leaders who were named as responsible 'risk owners' had left the organisation and for two risks no updates were provided on actions should have been completed August and October 2015. The risk register also did not contain some of the risks identified by inspectors, such as lack of a clear sepsis pathway for ED patients.
- Overall, we were not assured that the way senior leaders used the governance framework in the ED was providing sufficient and timely information to the trust senior management team on the concerns staff had identified in the department.

Leadership of service

- The ED was led by a triumvirate team of a senior matron who reported to the divisional manager, and both of whom reported to the clinical director.
- Staff reported that the leadership for ED did not recognise the risks to patients in the early phases of a new model and failed to adequately support staff who struggled to deliver safe services when support structures were changing.
- There was recognition that implementing changes from the action plan following our last inspection was a priority for the trust, and several changes to the leadership team followed. A new clinical director took up their post in November 2014, the senior matron commenced in December 2014 and a new Divisional Manager started their post in November 2015.
- Whilst phased plans to redesign and extend the space of the ED were occurring, the clinical director and divisional manager worked on changes to the overall model of care provided by the ED. This was introduced to address findings made by regulatory and best practice visits from the CQC, the CCG's and Emergency Care Intensive Support Team (ECIST) since 2014. The new model was discussed with staff in a programme of meetings since October 2015 and introduced on 16 February 2016. Some senior staff acknowledged the short timeframe there had been to implement the new streaming model.
- Senior leaders told us performance of the new model was reviewed weekly and considered concerns shared by staff. However, minutes showed that though concerns were captured formally they were not acted on. An action log for the new model listed dates of completed actions which managers admitted were not delivered.
- A major component of the new model was a move from triage to a streaming tool which was devised as most patients are ambulatory. Senior staff acknowledged that when there was capacity the model worked well but staff struggled when the department was busy.

- Some staff told us there was a consultation period of two months before introduction of the new model, which commenced at divisional level with the departmental leads with consultant buy in and teaching sessions and standard operating procedures were shared with staff though several staff were not aware of them.
- Medical staff on the whole were engaged in the changes and felt confident that the new model would deliver better outcomes and patient experience. Nursing staff in particular felt the change had been poorly introduced and shifted rather than addressed delays patients experienced meant that working relationships between doctors and nurses had become fragmented. They claimed that training to up-skill staff competencies in streaming and secondary assessment was not arranged to coincide with the new model.
- Staff reported that there was absence of medical leadership in relation to questions nurses asked about the new model. We noted at a senior management team meeting senior nurses in charge of streaming asked managers "what are we supposed to be doing with streaming?" and voiced concerns regarding medical involvement including "I have not seen the responsibilities of the doctors defined. [The medical team] dip in and out and it's not consistent for patient care." Staff told us they struggled to be heard by the senior medical team and that the delivery of the model of care changed depending on which consultant is on shift in the CDU.
- Nurses told us they did not feel all staff were adequately involved in change management within ED. Some told us they were disappointed in the approach the lead consultant and divisional manager had taken to introducing this new streaming process three weeks prior to an inspection without discussing and involving the nursing team. They told us all the nursing staff were struggling with it as "care had become very fragmented."
- Some nurses had returned from leave to find the new streaming had been put into place and had started a shift asking questions about how it should work. Some told us that having one nurse out the front streaming patients was not enough, where before they had two staff to triage. A staff member said "patient's think it is musical chairs." Another said "it can be difficult to follow a patient's care through with the new screening model which can be frustrating."

Culture within the service

- There was a divide between senior leaders, doctors and nurses since the introduction of the new working model. Doctors of all grades were almost unanimously positive and spoke of an open and supportive culture amongst consultants and managers. Nurses were disenfranchised and though they were able to be vocal about concerns since discussions regarding the new model had commenced their 'voice had been lost since the changes', and some said they were afraid to report patient safety incidents. A number of doctors spoke about nursing staff as a group who were unwilling to change, and similarly nursing staff told us doctors failed to listen to their concerns. Doctors were positive about the new streaming model though did recognise the potential for inappropriate streaming.
- There was acknowledgement from doctors that nurses did not feel comfortable changing from triage to streaming.
- Leaders told us the most recent GMC trainees report was positive and that emergency care was more cohesive now than before.
- Almost all nursing staff we spoke with told us they were well supported by the senior matron.
- Staff told us that consultants raised their voices and shouted at other staff and that these behaviours persisted as they were not dealt with. Some staff told us they were concerned that nurses were treated in a negative manner that was verging on bullying and intimidation despite trying to being sensitive to the changes.
- Some doctors felt nurses were not fully engaged with the new system and there had been a lack of support for consultants trying to implement change and resistance from nursing staff. They felt the vast majority of consultants were helpful and supportive and had never witnessed bullying behaviour. They spoke of a delay in specialties seeing patients.

Public engagement

- There was a patient experience group attended by managers and nursing staff, which reviewed the friends and family test results and some complaints.
- A total of twelve patient engagement sessions/events were held over the previous 18 months as part of a

programme. These events were co-designed with the patient experience team, patients and focused on a number of different topics including the service redevelopment.

Staff engagement

- In developing the new model of care over ten workshops were held with staff to engaged them, explain the rationale for its requirement and how staff would work in the newly defined areas. The success of this delivering this change was limited as nursing staff told us they felt that the new model was 'imposed without consultation.'
- Senior leaders told us there was a redirections working group which worked with key stakeholders to deliver appropriate access to emergency and primary care.
- Nursing leaders told us that nursing staff were engaged in the trust's activities via a variety of measures including the back to basics nursing campaign and enhanced development strategy for band 7 charge nurses to develop the ED vision.

Innovation, improvement and sustainability

- We were particularly concerned that the lack of unified agreement with the implementation of the new streaming model.

Medical care (including older people's care)

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

Information about the service

Medical care provided by the trust was delivered by five different divisions. The Emergency Services Division provide an acute medical unit comprising of 56 beds, 15 of which are allocated to acute frailty, and an Emergency Day Unit, for ambulant and non-ambulant patients, comprised of 3 clinic examination rooms, 10 beds and 8 reclining chairs. In addition the medical care includes: the cancer division provided inpatient oncology services (wards T10 and T14), the infection division provided an infectious diseases and respiratory service (T8), the medical specialties division provided elderly and general medicine (T7 and T10M) and the gastroenterology division offered gastrointestinal medicine services (T13 and endoscopy). There were a total of 203 inpatient beds spread between these wards. Additionally, there were seven preparation rooms, five treatment rooms and 16 recovery beds in endoscopy. There were 17607 patients admitted under the medical services between December 2014 and November 2015.

We visited the medical service at University College Hospital for four announced inspection days. During our inspection we inspected all wards, except T13S, and the endoscopy unit, and spoke with 79 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the medicine leadership team, 28 patients and 12 relatives. We reviewed 46 patient records and checked many items of clinical and nonclinical equipment.

Summary of findings

The medical services provided at University College Hospital required improvement. Senior staff lacked oversight of some issues within the service and risks we identified were not recorded on the relevant risk register; for example risks relating to the electronic prescription charts.

Staff reported incidents however feedback and learning from these was variable and senior staff did not complete ongoing follow up of actions identified as a result of investigations. For example a patient's grade three pressure ulcer was partially attributed to poor SSKIN care bundle completion (a five step model for pressure ulcer prevention) however we noted this was an ongoing issue throughout the medical wards suggesting learning from this had not been effective. Documentation across the wards was not completed to a satisfactory level; there were many incomplete assessment and care bundle forms and records without patient identifiable information. We also saw evidence some patients were not escalated appropriately when deteriorating and a lack of systematic identification of sepsis patients.

Patient outcomes were variable, including more deaths than expected in some clinical areas and a higher risk of readmission for some specialties. We saw evidence of some practice which was not in line with

Medical care (including older people's care)

recommendations, and variable safety thermometer results. Additionally a number of patients were seen to be receiving oxygen therapy without a prescription which is unsafe practice.

There were challenges with flow through the medical services, including endoscopy waiting times however endoscopy room utilisation was high and the waiting times were improving.

Patient feedback was mainly positive and we observed many positive interactions between staff and patients however there were occasions when patient privacy and dignity was not fully maintained. For example there were surveillance cameras in treatment areas within endoscopy which provided a live feed to screens in the recovery area which could be seen by anyone passing through the unit.

Staff were positive about the leadership team and opportunities for development in the service. We found staff had appropriate knowledge of consent and mental capacity principles and evidence of some effective multidisciplinary team working.

We rated safety across medical care as requires improvement because:

- There were a number of issues regarding the electronic prescription charts, including the risk of transcribing errors, patients receiving double doses of medicines and electronic system failures, which did not have mitigating measures in place. We saw many patients receiving supplementary oxygen without a prescription.
- A number of infection prevention and control procedures such as hand hygiene, use of personal protective equipment, patient isolation rooms and bare below the elbow principles were not correctly adhered to and placed patients at risk of healthcare acquired infections. Checks of emergency equipment were variable and several sharps bins contained items above the maximum fill line. Some patient bathrooms were messy and were used to store various items such as hoists which left patients unable to access hand washing facilities.
- We saw evidence of documentation across the medical services which was poorly filed, had not been fully completed, lacked patient identifiable information, was unclear who had written the entries and were stored insecurely. Escalation of deteriorating patients was not always correctly completed or fully documented and there was no evidence of a systematic process in place to identify patients with sepsis.
- Safety thermometer results were variable and included a high number of new Venous Thromboembolism (VTEs), particularly on AMU and T7. Staff knew how to report incidents and were mainly aware of what situations should be reported however incident feedback was inconsistent and learning points were not widely shared.

We rated effectiveness of medical care services to be good because:

- We saw evidence of competent medical and nursing staff working within the service, who had good knowledge of consent and mental capacity principles.
- Elements of effective multidisciplinary working were noted across the medical wards, including liaison with teams in the community.
- The HASU service received a B rating in the 'Sentinel Stroke National Audit Programme' (SSNAP) between April and June 2015.
- Patient pathways and clinical pro formas in use throughout medicine were based on and referenced to best practice guidance and national standards.

We rated caring of medical care services as good because:

- Patient feedback was positive and we saw numerous thank you cards expressing the gratitude of previous patients and their relatives.
- A number of patient feedback questionnaire results also showed patients were happy with the care they received.
- We observed numerous positive interactions between patients and staff.

Medical care (including older people's care)

- Staff provided emotional support to patients and their relatives, as well as signposting them to external support organisations.
- Patients were involved in discussions and decisions about their and were offered opportunities to ask questions and clarify information.

We rated responsiveness of medical care services to be good because:

- Staff recognised the changing needs of the local people and wider population and used a task force to identify and address any gaps in services.
- A range of support teams, such as translators and the drug and alcohol support team, were available to meet patients' individual needs.
- Referral to treatment time data was good.
- The discharge lounge was well utilised and 'pack and go' health care assistants helped to get patients ready to leave the ward to assist with patient flow through the hospital.
- Formal and informal complaints were appropriately handled by staff and patients received full and systematic responses to their concerns.

We rated well-led to be requires improvement in medical care services because:

- The leadership and governance did not always support the delivery of high-quality and safe person centred care. The risk register did not contain some risks we identified during our inspection and we saw the register was not always appropriately used or updated; for example no documented review of the falls risk between September 2013 and May 2015. We saw evidence to suggest that learning from incidents was not communicated consistently and ongoing reviews of practice by senior staff in relation to this did not occur, such as the poor completion of the SSKIN documentation.
- There was an apparent disjoint between ward and senior staff with regards to governance; junior grades were not engaging in governance activity and senior staff were not aware of this. Some senior staff also lacked oversight of issues in their individual area, for example not being able to identify the safety performance of their ward.
- There was little evidence of staff engagement, including in the development of the nursing strategy, however staff were confident in their leadership team and told us they were approachable and visible. There was a positive culture on the medical wards and staff told us they enjoyed their work.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

We rated safety of medical care services to be requires improvement because:

- Escalation of deteriorating patients was not always correctly completed or fully documented and there was no evidence of a systematic process in place to identify patients with sepsis.
- During our inspection we noted many patients receiving supplementary oxygen which had not been prescribed. Our findings were supported by results from the 'British Thoracic Society Emergency Oxygen Audit 2015' which showed 36.4% of patients received oxygen without a prescription. However the trust informed us that they have halved the number of patients receiving oxygen without prescription from 71.2% to 36.4% between 2011 and 2015
- There were a number of issues regarding the electronic prescription charts, including the risk of transcribing errors, patients receiving double doses of medicines and electronic system failures, which did not have mitigating measures in place.
- A number of infection prevention and control procedures such as hand hygiene, use of personal protective equipment, patient isolation rooms and bare below the elbow principles were not correctly adhered to and placed patients at risk of healthcare acquired infections.
- Checks of emergency equipment were variable and several sharps bins contained items above the maximum fill line.
- We saw evidence of documentation across the medical services which was poorly filed, had not been fully completed, lacked patient identifiable information, was unclear who had written the entries and were stored insecurely.
- Safety thermometer results were variable and included a high number of new Venous Thromboembolism (VTEs), particularly on AMU and T7.

However;

- Staff knew how to report incidents and were mainly aware of what situations should be reported.
- Mandatory training uptake across the medical wards was good and there were suitable processes in place to support staff in staying up to date.
- There was evidence of clear actions taken to reduce the risk of patients falling on the wards, such as heat map monitoring and grouping high risk patients together.

Incidents

- A computer based incident reporting system was used throughout the trust and could be accessed via any computer within the hospital. Staff were aware of how to report incidents and which type of situations should be reported, however not all staff were clear about the need to report near miss incidents.
- There were 1247 incidents reported across the medical services between January and December 2015 and most incidents were rated low or no harm. Most incidents were reported on AMU (382), followed by T07 (265) and T08 wards (262). Less incidents were reported were on T10 and T10M (86 combined) as this ward had been open for five months.
- The most common types of incidents which occurred were falls (384), medicines errors (204) and pressure damage or moisture lesions (199). These themes were consistent across the medical services and no ward was identified as being particularly high risk for these themes.
- A total of 11 serious incidents (SIs) were reported by the medical services between August 2014 and July 2015. Four of these were pressure sores which met the SI reporting criteria which meant they were identified as a grade three pressure ulcers. We saw evidence that senior staff conducted appropriate investigations into the SIs which occurred and made suitable recommendations for improvement.
- Never events are SIs that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Although each Never Event type has the potential to cause serious potential harm

or death, harm is not required to have occurred for an incident to be categorised as a Never Event. Between August 2014 and July 2015, no never events were reported by the medical services.

- Staff told us feedback from individual incident reports was variable; some staff told us they received comprehensive and timely feedback whereas other staff told us they did not hear anything after submitting an incident form.
- Learning points from incidents were identified after investigation and senior staff told us these were shared with staff on posters, during handovers, safety huddles and team meetings. However, most staff we spoke with were unable to identify any learning from incidents which had been communicated to them by senior staff and one senior staff member was unable to identify any learning which had occurred following medicines errors on their own ward.
- Staff told us any learning points that were identified were sometimes shared within the division in which they occurred but there were no designated pathways for sharing learning across divisions.

- Morbidity and mortality meetings were held at varying intervals depending upon the speciality involved. Some registrars and specialist trainee doctors told us they attended these meeting regularly whereas others were unclear where and when they took place.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Senior nursing and medical staff were familiar with duty of candour and were able to explain what this meant in practice. They provided examples where they had adhered to this duty and demonstrated this in written letters to patients and their relatives.
- Out of 16 junior medical and nursing staff we asked, 13 were unaware of the term duty of candour. They were however able to identify the need to be honest about any mistakes which had been made and offer an apology to an effected patient.

Safety Thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. A single day 'snapshot' of patient harms was submitted to the database on a monthly basis. Safety thermometer data detailed below covered the period February 2015 to February 2016; however we noted some gaps in reporting safety thermometer results. For example no data was reported for T7 between June and August 2015.
- Safety thermometer data was displayed on quality and safety boards on the entrance corridors to all wards, however we noted the incidence of CUTIs was not displayed. Staff told us this was due to the layout which was used trust wide for these boards.
- There were seven new pressure ulcers recorded by the safety thermometer and all but one of these occurred on T8. We observed there were measures in place across the medical wards to reduce the risk of pressure ulcers occurring, such as use of the SSKIN care bundle and pressure relieving equipment. Staff also spoke positively about the involvement of the tissue viability teams in supporting them with managing 'at risk' patients.
- A total of 15 CUTIs were recorded in the period specified and most were reported on T7 (six) and AMU (five). Senior staff told us all catheters were reviewed on a daily basis during morning board rounds and removed as soon as possible to limit the risk of CUTIs occurring, however we observed that this discussion did not always occur during our observation of these meetings.
- There were 15 falls with harm reported on the safety thermometer and 11 of these occurred on T7. Staff told us this was due to a high number of patients with a high risk of falling on that ward and that senior staff had introduced several measures to reduce the number of falls. Despite T07 being a frail elderly unit, in the last calendar year there were no fall related fractures reported during this period, which is highly significant for such a high risk patient environment/ population.

- The safety thermometer showed 40 new occurrences of VTE across the medical wards. The majority of these occurred on AMU (18) or T7 (nine). Both of these wards had one particularly poor month where the number of new VTEs spiked (eight in August 2015 on AMU and five in December 2015 on T7) and senior staff told us this was discussed at clinical governance meetings. The outcome was a campaign on VTE assessment completion and increasing pharmacist involvement in checking pharmaceutical VTE prophylaxis.

Mandatory Training

- A number of training topics were compulsory for all trust staff. For example fire safety and information governance. There were specific topics identified for different staff groups and were delivered in classroom based sessions or via e-learning systems.
- The trust target for all mandatory training completion was 90% and we noted that all medical wards either met or exceeded this target.
- Information governance training was completed every two years and uptake ranged from 85% on AMU to 100% on T7 and T10, with four wards achieving 95%.
- All wards exceeded the 90% target for infection prevention and control training, which had to be completed every two years.
- All wards met the 90% target for medicines management awareness training.
- Safeguarding adults level two training had been completed by 81.7% and 91.9% of staff on AMU and T7 wards respectively. All other wards met the 90% training target. Safeguarding children level two training was completed by more than 90% of staff on all medical wards.
- Staff told us their line manager or practice nurse educator emailed them to highlight if there were any topics of mandatory training which needed to be completed or updated and we saw evidence of this on the wards.
- In a drive to improve mandatory training uptake on T8, staff were not able to access funding or study leave for external courses unless their mandatory training was up to date. We noted that mandatory training on T8 exceeded the the trust-wide 90% target, with 95% completion.

Safeguarding

- The medical wards had access to the hospital safeguarding team on a bleep referral basis. There was a trust-wide safeguarding policy in place which was accessible to all staff via the intranet.
- Staff could identify the types of situations which would trigger a safeguarding concern and most were aware of how to make a safeguarding referral to the specialist team as well as identify who the safeguarding lead was. Some junior staff told us they would discuss any safeguarding concerns with the nurse in charge rather than making a referral independently.
- We saw examples of appropriately completed safeguarding referral forms and observed discussions about safeguarding issues take place during ward rounds and multidisciplinary huddles. One manager told us there had been "a massive improvement in safeguarding practices" within the medical wards.
- Staff had been provided with "Safeguarding adults and the Mental Capacity Act" guidance booklets which we observed many staff carried with them during our inspection. Staff told us they had only been provided very recently and they were unfamiliar with the contents of the booklet but would refer to it if they had any queries about safeguarding or mental capacity.

Cleanliness, infection control and hygiene

- The medical wards were mainly visibly clean, including clean utility room, the sluices and patient bays. Some high level dust was noted including on top of curtain rails and patient monitors.
- Green 'I am clean' labels were used to identify equipment which had been cleaned and was ready to use. These labels identified the date when the equipment was last cleaned and we saw these in use throughout the medical wards. On T10 (oncology) we observed two patient observation machines which were labelled as clean and dated 23/02/2016 (two weeks prior to our inspection), however these machines were being used by staff and put away without changing the label.
- We inspected commodes on all medical wards and noted that almost all were visibly clean; one commode on T10M had dried urine on the seat.

Medical care (including older people's care)

- The trust-wide 'Invasive Devices Tool' was in place to assess any invasive devices patients had, such as cannulas, catheters and central venous lines. Each line was assessed on a daily basis to ensure it was still necessary and was not showing any signs of infection. We saw intermittent use of this tool across the medical wards; however there were often gaps in the documentation such as days where assessments had not been documented as completed.
- Patients on the medical wards had weekly nasal swabs to test for methicillin-resistant staphylococcus aureusis (MRSA) and treatment was commenced if appropriate.
- Basic personal protective equipment (PPE), such as gloves and aprons, was available throughout the medical wards and we saw evidence of other types of PPE, for example face masks, available in store rooms.
- We observed staff using PPE to complete patient care tasks and to enter isolation areas. Most staff removed and disposed of their PPE correctly however we observed gloves incorrectly discarded in black general waste bins and some staff leaving isolation areas still wearing PPE.
- We observed a staff member drop a handful of gloves onto the floor of the ward. The staff member then picked the gloves up and placed them back in the box for use by other staff members which was not appropriate practice or hygienic. This was highlighted to a senior nurse on the unit who disposed of the box of gloves and raised the issue with the staff member concerned.
- We saw evidence patients who required barrier nursing, such as those with MRSA colonisation, were accommodated in individual side rooms if possible. Isolation warning signs were used to highlight what measures were required for each isolated patient, for example if staff needed to wear a protective face mask. We observed staff usually adhered to the guidance provided on the isolation signs however we observed the doors to isolation rooms were frequently left open.
- Patients in bays were separated using disposable curtains, which were marked with the date they were put up. Staff told us the curtains were changed every six months or more frequently if they became soiled or if a barrier nursed patient was cared for within the bed space.
- A separate preparation and recovery room was used for barrier nursed patients in endoscopy to reduce the risk of cross infection for other patients. Barrier nursed patients had their procedure last on the endoscopy list so the treatment room could be deep cleaned after use.
- There were suitable procedures in place to ensure used endoscopy equipment could not contaminate clean equipment, including separate rooms for accessing the autoclave depending upon whether staff were placing used equipment in the autoclave or removing clean equipment from it. Used equipment was identified by being placed in red storage plastic and clean equipment was stored in clear plastic.
- Infection prevention and control practices were mainly suitable however we saw some examples of poor infection control practice on the medical wards. For example we observed a nursing assistant completing patient observations without cleaning the equipment between patients and staff moving a computer on wheels between patient bed spaces, including isolated patients, without cleaning it. Additionally, we observed a phlebotomist accidentally drop an item of blood taking equipment into an orange clinical waste bag (which contained gloves that had been used when taking blood from patients), remove the item from the rubbish bag and take the item to be used with the next patient. We raised this issue with a senior nurse on the ward who spoke to the member of staff concerned.
- There were sufficient hand washing facilities throughout the medical wards and alcohol gel was available at regular intervals, including in each patient bed space and in most bathrooms.
- The entrance doors to the medical wards had automatic gel dispensers to ensure people who entered the wards cleaned their hands first. We observed some members of staff bypass the automatic gel system and fail to clean their hands on entry to the wards.
- On the wards most staff cleaned their hands with alcohol gel or soap and water according to the five

moments of hand hygiene, however some staff displayed poor hand hygiene practices. For example during a ward round on AMU we observed infrequent hand cleaning by the consultant and supporting doctors.

- Hand hygiene audits were completed on a monthly basis on wards throughout the hospital, however we noted some gaps in audit results for all wards between June and November 2015, other than AMU which submitted results each month. Results from the audits showed hand hygiene compliance was mainly above 90%.
- We observed some occasions where staff were not bare below the elbows within clinical areas. For example we saw two clinical nurse specialists (CNS) wearing outdoor fleece jackets with long sleeves to enter and, shortly afterwards, leave an isolated patient's room. This was seen by the matron who challenged and corrected the staff members involved. We also observed some medical staff wearing rings with stones, watches, bracelets and nail varnish.
- On T8 we noted breakfast trays including half eaten meals and old cups of tea had been cleared and were stored in the corridor on a trolley. These trays remained in place for over three hours.

Environment and equipment

- Monthly environmental audits were completed across the medical wards by representatives from infection control, estates and clinical support services. They assessed the environment for any improvements or repairs that needed to be completed as well as ensuring the relevant areas were free from clutter and did not pose a fire risk. We saw evidence that actions were identified to correct problems identified although it was unclear how this would be communicated to the relevant people (for example the physiotherapy team who were required to move items stored in a ward cupboard) and what follow up would occur.
- Resuscitation trolleys were available at appropriate intervals throughout the medical wards and endoscopy. Trolleys were secured with plastic snap locks so it was clear if someone had accessed the resuscitation equipment. Trolleys were usually checked daily although we noted some gaps on the checking documents (such as seven gaps in six weeks on the endoscopy resuscitation trolley) which indicated they were not always checked every day. We reviewed the contents of three trolleys and found their contents to be correct against the check list and in date. However, we observed there was no suction tubing or liner available on a trolley on AMU which meant it could not have been used immediately in the event of an emergency. This was corrected by the nurse in charge when we raised this as a safety concern.
- A resuscitation 'grab bag' was available in the discharge lounge and staff told us this was to be used with patients or visitors who required cardiopulmonary resuscitation in the atrium area of the hospital. A checklist for this bag was available for August and September 2015 where a total of 26 checks had been completed. Apart from this record, sporadic checks only were documented. Staff were not clear about the checks required on this equipment.
- We reviewed various consumables throughout the medical wards and found most were in date. Some out of date items were identified and these were disposed of by ward staff when highlighted by the inspection team. Most items were stored correctly however we identified some boxes stored directly on the floor in T7 which was not correct storage. We also observed some items were inappropriately stored in the sluice cupboards, for example toothbrushes and shaving equipment.
- Sharps bins were readily available throughout the medical wards however we noted several sharps bins were filled above the maximum fill line, including on resuscitation trolleys. We also noted some sharps bins contained inappropriate items, such as personal protective equipment (PPE), and had not been correctly labelled.
- We observed a phlebotomist forcing a syringe and needle into a sharps bin which already had items protruding out the top of the bin lid. The phlebotomist did not address the full bin and we escalated this to a senior nurse on the ward who corrected the issue and spoke to the member of staff involved.
- There were sufficient bathrooms to meet patients' needs throughout the medical wards and we saw

patients were allocated to specific bathrooms where possible. Several bathrooms we inspected were messy with discarded equipment such as toothbrushes and toothpaste on the sinks and used pyjamas on the floor.

- In the bathrooms, we noted that toilet paper was usually available from a wall mounted dispenser. However, these were often positioned some distance from the toilet and so patients had to lean far over to one side to reach the toilet paper. This placed patients at risk of falling from the toilet.
- A patient bathroom on T8 was used to store various items of equipment, such as wheelchairs, hoists and a bath seat. The storage of these items meant patients could access the toilet but were unable to use hand washing facilities within the bathroom. Staff were unclear about whether this bathroom should be locked or if patients were supposed to use it. We observed patients using this bathroom during our inspection.
- We inspected many items of equipment across the medical wards (including hoists, observations machines, suction machines, defibrillators, computers and monitors) and found them to have been recently portable appliance tested (PAT) and within their service date.
- Equipment maintenance spreadsheet documented serial numbers and service data for all medical equipment which ensured equipment could be located and tracked in case of any problems occurring.

Medicines

- Pharmacists accompanied medical teams on ward round when possible. We observed the pharmacists reviewing patient medicines to identify any undesirable interactions between medicines and clarifying prescriptions with the doctors on ward round as the patient bedside.
- Medicines were stored in locked cupboards within clean utility rooms and keys for these cupboards were held by the nurse in charge of each ward. We noted medicines cupboards were generally tidy and it was easy to locate specific medicines within them.
- Some medicines were stored in lockable medicines fridges within the clean utility rooms. Documentation showed fridge temperature checks were completed on a daily basis on most wards although there were some gaps in the recording documentation.
- Controlled drugs were stored in wall mounted, lockable units. The CD stock books were stored within the CD cupboard and books we reviewed showed accurate documentation of stock levels. The keys to the CD cupboard were held by the nurse in charge on each ward.
- We observed nursing staff accessing, documenting, preparing and administering CDs correctly, including the use of two nurses to complete these stages and suitable patient checks.
- Oxygen cylinders were mainly stored appropriately in designated racks throughout the medical wards. Cylinders we checked were seen to be in date and empty cylinders were usually stored separately from full ones.
- Medicines were prescribed on electronic charts throughout the medical wards, however some patients on AMU still had paper charts in use from their stay in the emergency department. We were concerned that transcribing errors could occur when changing the prescription from paper to electronic format and also that patients with a paper and electronic chart may be administered medicines twice if staff were not clear which system was in use. Senior staff were aware of this risk but there was no evidence to suggest this was being addressed or monitored, other than through incident reports, and it was not documented on the risk register provided to us by the trust.
- On the electronic medicines chart, it showed medicines were available for administering one hour before their prescribed time and for one hour afterwards. We were concerned that patients could be given their medicine late on one dose and early for the next (for example medicines prescribed four hourly at 10am and 2pm could actually be given at 11am and 1pm) which would mean they had the doses too close together. Staff told us this would not happen as the computer system would not allow this. However, staff did not electronically sign medicines as administered

until the patient had taken it and so they might not be alerted until the error had already occurred. We did not see evidence that this issue was documented on the risk register provided to us by the trust.

- Staff commented that the electronic medicines system was often very slow to use and "crashed at times". They told us the system failures were usually short lived but there were no processes in place to enable patients to have medicines while the system was not working.
- During our inspection we noted many patients receiving supplementary oxygen which had not been prescribed. Our findings were supported by results from the 'British Thoracic Society Emergency Oxygen Audit 2015' which showed 36.4% of patients received oxygen without a prescription. However the trust informed us that they have halved the number of patients receiving oxygen without prescription from 71.2% to 36.4% between 2011 and 2015.
- Patients with some medical conditions should not be exposed to additional oxygen for safety reasons and consistently providing oxygen without a prescription could place patients at risk.
- Patient tablets to take away (TTAs) were organised by the pharmacy team, including at weekends. Staff and patients told us they experienced significant delays when waiting for TTAs and pharmacy staff explained this was usually due to the prescriptions reaching pharmacy at the last minute.

- The trust aimed to have a maximum of 20% of TTAs prescribed on the day of patient discharge. From November 2015 to January 2016 the medical specialities division did not achieve this target as between 49% and 51.4%of TTAs were prescribed on the same day the patient went home.

Records

- Patients admitted to the medical wards had a nursing note folder which included care plans, specific assessments and observation charts. These folders were stored in holders located outside of the patient's room or at the end of their bed. A separate medical note folder was used to document involvement from the patient's medical team and allied health professionals. The medical notes were stored in key pad lockable notes trolleys located in the corridors on the medical wards.
- Senior staff told us they completed weekly spot checks of patient records and would highlight any issues with staff at the time. They told us that in their opinion patient records were generally well completed.
- We reviewed 46 patient records and saw notes were commonly filed out of sequential order and not in clear sections. There were often loose sheets which could be easily lost when opening or carrying the notes folder. In one set of medical notes the patient records for two days at the start of their admission were not in the medical notes and it was unclear where these documents had gone.
- We saw several documents (for example AMU clerking pro formas, fluid charts and care plans) which did not have any patient identification such as name, hospital number or date of birth documented. This meant it was unclear who the documentation referred to and increased the risk of note entries being made incorrectly or wrongly filed.
- Some medical notes we reviewed did not have daily entries from medical staff despite patients and staff assuring us the medical team had been to see the patient. This was found in the records of patients on the main medical wards and medical outlier patients. In one set of notes, there was no documentation from the medical team for three days despite the most recent entry being from an on call doctor who reviewed the patient due to low blood glucose levels.
- We observed many note entries where it was unclear who had written the documentation. In some cases there was no signature or identifiable information at all, whereas in other records a signature was present but was not legible.

- We saw evidence of some poor documentation relating to nasogastric (NG) tube placement. For example on T10 (elderly medicine) a patient's NG tube became misplaced and there were no documented length checks after re-placement to ensure it remained in the correct position.
- The 'UCLH Nutrition Screening Tool' was used as a weekly patient assessment where there were concerns

about patient weight or nutritional status. We observed these were rarely completed correctly, for example on T8 we saw this filled in on the 18 February 2016 then on 3 March 2016, which showed the assessments were completed more than a week apart. Additionally, the assessment on 3 March did not record the patient's weight.

- We saw evidence of many incomplete care bundles, for example the SSKIN care bundle which was used to assess patient risk factors and aimed to reduce the occurrence of pressure ulcers. We noted the investigation into one serious incident identified incomplete SSKIN care bundles as contributing to the development of a grade three pressure ulcer. Appropriate actions were identified as a result of this investigation. However our inspection findings demonstrated that learning and improvement in this area had not been effective as these care bundles continued to be incomplete.

- Formal documentation audits were completed annually by senior staff. Results from T10 in 2015 showed most areas audited (such as whether each sheet had the patient's name, date of birth and hospital number) scored 90% or above. Lower scores were recorded for entries written in dark ink (60%), time of entry documented (50%) and clarity of who wrote the notes (70%). There were no actions identified as a result of the audit findings. The results of this audit were generally better than the notes we reviewed during our inspection.

Assessing and responding to patient risk

- In line with NICE guidance, the 'National Early Warning Score' (NEWS) was used across the medical service to identify patients at risk of deterioration and trigger escalation to the patient's medical team or the 'Patient Emergency Response and Resuscitation Team' (PERRT).

- We reviewed hospital audit data for T10M and T7 relating to the completion of patient observations and correct use of NEWS. Results for T10M in December 2015 showed 92.3% of observations were fully completed (an improvement from 66.7% in November 2015) and NEWS was correctly calculated (an improvement from 58.3% in November 2015). Results for T7 showed 100% of observations were fully completed and had an accurate NEWS calculated in November and December 2015.

- Patient records we reviewed showed patient observations were usually completed at appropriate intervals and patient care was escalated correctly however we also saw some occasions when this was not the case. For example, on T8 we saw evidence that a patient with a NEWS (score) of 10 was not immediately escalated. Instead, the observations were taken again 15 minutes later (NEWS of 7). An entry was made in the notes 30 minutes later stating "I need to bleep the on call doctor…", however it was unclear if this occurred as there was no follow up documented by the nursing staff and no entry from a doctor in the medical records.

- Hospital audit data from November 2015 to January 2016 showed variable results for VTE completion across the medical wards. The endoscopy unit performed well with 100% of VTE assessments completed however T7 was the only other area which had VTE completion consistently above 90%. These results reflected our inspection findings.

- There were 16 monitored beds on AMU which were used to oversee observations of patients with heart problems or those who were particularly unwell. Monitors with alarms were placed within each bed space to alert staff if patient observations deteriorated. In one bay area, an additional alarm speaker relating to each patient was located on the nurse's desk to highlight when the patient observations were outside of the desired range. However we noted that the bedside alarms were set at low volumes and these additional speakers were turned around so their sound was partially blocked. This made it difficult to hear when the alarms were sounding which placed patients at risk as staff may not have been alerted when their observations were changing.

- Throughout the medical wards there was no systematic process in place for identifying and managing patients with sepsis. This placed patients at risk as there was no care bundle in use to ensure patients, for example, received their first dose of antibiotics within one hour of sepsis identification

which is the recommendation of best practice guidance. A specialist trainee doctor told us they were involved in a trust-wide sepsis project to develop an identification sticker to highlight when a patient was recognised as having sepsis.

- All elderly medicine patients were screened by the physiotherapy team as part of their falls risk assessment on admission to hospital. Other medicine patients were referred to physiotherapy if they were considered to be at risk of falls by ward staff.
- An investigation into an SI which involved in a patient falling and sustaining a fractured hip recommended that patients should undergo falls assessments upon moving to a new area. However during our inspection we noted this did not always take place or was only partially completed.
- On T8 we noted use of a 'falls heat map' which identified where falls mostly occurred on the ward. Staff told us they expected most falls to take place out of view of the nursing stations such as in individual rooms and bathrooms but this was not the case when analysed. Staff explained they tried to have a greater presence in bay areas to reduce the likelihood of falls occurring.

- Some medical wards accommodated patients who were assessed as being at risk of falls in a bay together and ensured there was always a staff member present in the bay. Staff were positive about the effect this had on the number of patient falls but this had not been formally audited.

Nurse Staffing

- Nurse staffing levels throughout the hospital were reviewed annually in relation to the changing levels of patient acuity and dependency. Staffing levels were also review in relation to incidents which occurred, for example an incident on T8 led to the increase in nursing establishment by 8.7 whole time equivalent registered nurses.
- Staffing levels were reviewed on a daily basis at site management meetings and staff were moved between wards to maintain safe staffing levels if required. Staff on the medical wards told us they did not often have to work on other wards.
- Hospital data from September to December 2015 showed actual staffing levels usually met 90% of the planned numbers across the medical wards. Most wards showed improvement in actual staffing numbers from September 2015 onwards however T8 continued to have less than the target 90% during daytime shifts each month.
- Vacancy rates throughout the medical wards were within expected limits, other than on HASU and T8 which had high vacancy rates of 30.8% and 18.7% respectively. Nurses on several of the medical wards identified band six vacancies as having a notable effect on ward skill mixes and staffing as there were less senior colleagues available for support.
- Information provided by the hospital showed nursing assistants used to backfill where registered nurses were not working and the ward sister was also used to provide clinical care in some cases. There was also some use of bank and agency staff to maintain safe staffing levels.
- All new bank and agency staff were orientated and inducted to their area of work. Specific medicine administration competencies were assessed for these staff members before they were able to give medicines to patients.

- Staffing levels had been risk assessed by the leadership team and were recorded on the risk register in several areas of the medical services, along with difficulties in recruiting staff. Actions were in place to mitigate and address risks, for example developing band 5 staff into band 6 posts.

Medical Staffing

- Patient care was provided and led by specialist consultants on the medical wards. Consultants completed daily ward rounds and were involved in multidisciplinary meetings and discharge planning where appropriate.
- Consultants were supported by a range specialist registrars, core medical trainees and foundation level doctors. Consultants formed 34% of the medical staffing and this was in line with the national average. The proportion of registrar level doctors was greater than the national average (45% in comparison with

39%) and there were a lower proportion of specialist trainee doctors (14% in comparison with 22%). Staff told us this meant there was a greater level of expertise at ward level.

- Specialist trainee and foundation year doctors said they were well supported by their senior colleagues and told us they were able to contact their consultant or registrar easily. They identified clear routes for escalation of patient care.
- Information provided by the hospital indicated there were sufficient numbers of medical staff to support patient care, although we were unable to see this reflected on the wards during much of our inspection due to the doctors' strike. Consultants said they had enough supporting medical staff to provide a suitable service to patients.
- Additional evening cover for medical patients was provided via the 'Tower Medical Rota' which allocated core medical trainees to support patient care between 5pm and 10pm.
- Between 10pm and 9am, the 'Hospital@Night' team (H@N) were responsible for all patients within the hospital. There was a duty medical registrar (DMR) who led medical care in the emergency department and AMU, with the support of three foundation year doctors taking care of patients on the wards.
- On call consultants were available overnight to provide support for the H@N team. The consultants provided telephone advice or could go into the hospital to provide assistance in person for complex or deteriorating patients.
- The ward doctors handed over to the H@N team during a specific handover meeting which had attendance from doctors and senior nursing staff from all ward areas. The online patient information system had a facility to create a list of patients who needed a review overnight however during our inspection we saw this was not used and no patients were specifically identified as needing a review overnight.
- There were six incidents relating to medical staffing on the medical wards reported in 2015, including five which highlighted medical staffing issues overnight. Information provided by the hospital demonstrated how medical staff were redeployed to account for the staffing issue to ensure patient care remained safe.

Major incident awareness and training

- There was a trust-wide major incident policy that was available to all staff via the hospital intranet. Staff told us the site management team were responsible for initiating and implementing the major incident emergency plan when needed. Staff knew that a ward based contact person would be identified (usually the nurse in charge) and all instructions from the site team would be communicated via this member of staff.
- Staff told us there would be a significant increase in demand for the hospital services if a major incident occurred nearby. They told us they would need to discharge as many patients as possible so beds were made available for acutely injured patients.
- Staff we spoke with had not been involved in specific major incident training or simulations and were unsure if they were expected to do this.

Are medical care services effective?

Good

We rated effectiveness of medical care services to be good because:

- We saw evidence of competent medical and nursing staff working within the service, who had good knowledge of consent and mental capacity principles.
- Elements of effective multidisciplinary working were noted across the medical wards, including liaison with teams in the community.
- The HASU service received a B rating in the 'Sentinel Stroke National Audit Programme' (SSNAP) between April and June 2015.
- Patient pathways and clinical pro formas in use throughout medicine were based on and referenced to best practice guidance and national standards.

However;

- We saw evidence of practice which was not always in line with national recommendations, and no systematic approach to identifying patient with acute kidney injury.
- The 'Summary Hospital-level mortality Indictor' (SHMI) showed more patient deaths in oncology and gastroenterology than predicted and patient outcomes in national audits were variable.
- Readmission rates for non-elective elderly medicine and elective oncology and gastroenterology patients were worse than the national average.

Evidence-based care and treatment

- Various patient pathways were used to guide treatment for specific conditions and diagnoses, for example the abnormal electrolyte referral pathway, the atrial fibrillation pathway and the collapse and syncope pathway. These pathways were based on best practice guidance, such as from the National Institute for Health and Care Excellence (NICE). We saw evidence these pathways were used for appropriate patients on the medical wards.
- Clinical guidelines were in place to guide patient care and treatment for specific procedures and interventions. We saw evidence the clinical guidelines were written in line with current best practice guidance and referenced national standards. For example the clinical guidelines for 'Insertion and Removal of Central Venous Catheters by Specialist Nurses' referenced research articles from the 'Journal of Vascular Access' and specific NICE guidance. The neutropaenic sepsis policy also referenced NICE guidelines.
- Patients were reviewed by a consultant twice per day on AMU in line with best practice guidance. Once transferred from AMU, most patients were seen during a consultant led ward round.
- An endoscopy policy was available on the intranet and was seen to be within the date of review. The policy contained various guidance (including indications for endoscopy, consent procedures and medicines) as well as references to specific best practice recommendations such as from the 'Academy of Medical Royal Colleges'.
- Evidence based care bundles, such as the SSKIN care bundle, were used to assess and guide patient care regarding specific issues like pressure ulcer prevention.
- Staff across the medical wards were not aware of a system in place to identify and manage patients with acute kidney injury (AKI). The absence of this type of system meant the service was not compliant with a mandated level three patient safety alert from NHS England which had been disseminated in April 2015. This was recorded on the risk register for the medical services in January 2016 and ongoing assessment was occurring at the time of our inspection.
- We saw evidence the World Health Organisational (WHO) surgical checklist was completed correctly and at appropriate times in the endoscopy unit.
- Joint Advisory Group' (JAG) accreditation is a formal recognition that an endoscopy service is fully competent to deliver against specific measures, as identified by the' Global Rating Scale' (GRS) standards. The endoscopy unit had not been JAG accredited since December 2013. Information provided by the hospital stated that each of the requirements for JAG reaccreditation had been completed, with the exception of waiting time compliance. A re-inspection of the unit by JAG was anticipated for later in 2016.

Nutrition and hydration

- Patient nutrition and hydration was supported by dieticians within the hospital. Patients could be referred for dietetic review if there were concerns about their weight or calorie intake. The 'UCLH Nutrition Screening Tool' was used as a weekly patient assessment where there were concerns about patient weight or nutritional status.
- Patients with other difficulties with eating and drinking (such as coughing when drinking or struggling to use cutlery) could be referred to speech and language therapy or occupational for relevant assistance.
- As a result of a ward project to improve patient nutrition, a red tray system was used on T7 to identify patients who required assistance with eating. There

was no system to identify patients who needed assistance on the other medical wards, although T8 also introduced the red tray system on the last day of our inspection.

- We observed lunchtimes on the medical wards and saw that patients were assisted to an upright sitting position to eat their meal. Patients were helped to feed themselves or assisted appropriately if needed.
- Most patients told us they had sufficient time to eat their meals on the wards however a patient on AMU and another on T8 told us their meals had been removed before they had finished eating.
- Fluid balance charts were used to monitor the fluid intake and output for some patients. We saw evidence these were usually put in place appropriately however most fluid charts we reviewed had not been fully completed; many charts were sparse and most did not demonstrate a calculated overall fluid balance. This meant the fluid charts were not used to effectively monitor patient hydration.
- We observed patients had access to water at their bed side and were offered hot drinks at regular intervals throughout the day. However, we observed two patients on different wards (AMU and T7) asking for hot drinks in between drinks rounds; one patient was told to wait until the next round and the other had to ask several times before a member of staff brought the drink.
- Food delivery and the nutritional experience of patients on T8 was recorded on the risk register in October 2013 and was ongoing at the time of our inspection. We saw actions logged to improve patient experience for example additional dietetic support.
- There were 36 incidents relating to nutrition in 2015. These incidents included availability of certain types of food, such as pureed options, and delays to assessment by a speech and language therapist (SALT), particularly due to lack of SALT funding on AMU.

Pain relief

- Patient pain was usually managed via oral or intravenous (IV) medicines. Patient controlled analgesia (PCA) and epidurals were also available when required, although these methods of pain relief required the support of the hospital pain team, who could be accessed via a bleep referral system.
- Senior staff told us patient pain was assessed every time their routine observations were completed and this was documented on the observations charts. We observed staff across the medical wards completing patient observations without asking about pain and noted many patient records without a pain score recorded.
- An internal hospital audit for T10M and T7 also showed pain at rest was not always documented alongside the patient observations (T10M: 75% in November 2015 and 61.5% in December 2015. T7: 41.7% in November 2015 and 53.9% in December 2015). Pain on movement was documented less frequently than pain at rest on both wards; 41.7% in November 2015 and 53.9% in December 2015 on T10M, 84.6% in November 2015 and 63.2% in December 2015 on T7.
- Patients told us their pain was generally well managed and most agreed that they receive pain relief in a timely manner.
- Patient feedback questionnaire results from January to December 2016 showed between 94% and 97% of patients thought hospital staff did everything they could to manage the patients' pain. These results were slightly lower than the 98% trust target.

Patient outcomes

- The HASU service at the University College Hospital participated in the 'Sentinel Stroke National Audit Programme' (SSNAP) which assessed the quality of care provided at stroke services across the country. A score between A and E was awarded, where A marks the best quality care. Between April and June 2015, the stroke services achieved a B rating; the key clinical indicator score was A, but data quality reduced this to a B. This was an improvement from the previous scoring period where a D rating was awarded.
- In the most recent national Heart Failure Audit in 2013/4, the hospital performed better than the national average for all indicators relating to inpatient care and discharge from hospital.

Medical care (including older people's care)

- In the most recent (2013) results from the 'National Diabetes Inpatient Audit' (NaDIA), the hospital performed worse than the national average in 14 out of 20 domains. This was not documented on the risk register, however we saw an in depth action plan to address the areas of poor performance.
- For non-elective medical oncology patients there was lower risk of unplanned readmission to hospital following discharge in comparison to the national average and a slightly lower risk for non-elective general medical patients. Non-elective geriatric medicine patients were more likely to be readmitted to hospital after discharge than the national average (.
- Elective medical oncology and gastroenterology patients had a greater risk of readmission to hospital than the national average.
- The 'Summary Hospital-level Mortality Indicator' (SHMI) is a tool which reports on the actual number of patient deaths against the expected number of deaths each year. The SHMI for general medical, respiratory medicine and geriatric patients was lower than anticipated between July 2014 and June 2015, which meant there were less patient deaths than expected. The SHMI for oncology and gastroenterology patients was higher than expected which meant there were more patient deaths than predicted.

Competent staff

Nursing:

- All staff were required to attend a trust induction within four weeks of commencing employment. This induction covered the core expectations of staff, some aspects of mandatory training and an overview of the trust values and vision.
- All levels of staff in the medical services underwent induction and orientation to their area of work. This was usually completed by the charge nurse responsible for the ward. Some staff also told us they were invited to the ward prior to their start date to become familiar with the ward before starting work.
- New starters were allocated to a mentor and worked as a supernumerary member of staff until basic competencies were achieved. Specific competencies had to be signed off for certain tasks, like medicines administration and we saw evidence of specific competencies in different areas of medical care; for example there was a particular competency document for nurses working within endoscopy and different competencies for nurses working within oncology.
- An abbreviated version of the trust competencies were completed with agency staff at the start of their first shift within the trust. Any specific local competencies would also be completed, for example tracheostomy care.
- Staff described joint training days for staff working on AMU and T7 which were based on specific themes such as delirium, Deprivation of Liberty Safeguards (DoLS), infection control and falls. These sessions were led by practice nurse educators who were then also able to follow up on learning points in the clinical settings.
- Student nurses were allocated to a placement supervisor and told us they helped guide their development and suggest learning opportunities during their clinical placement. They told us they mainly worked with their supervisor on shift but would have another person allocated as a point of contact if working a different shift to their original supervisor.
- Student nurses had designated notice boards on some wards which highlighted specific contact details and learning opportunities. For example, on T8 the noticeboard advertised opportunities for student nurses to be involved in audit activities on the ward.
- Senior staff on T8 described how they were developing the role of nursing assistants to make them more highly skilled in certain areas. For example, nursing assistants were often using to care for patients living with dementia or a learning disability on a one to one basis and so training programmes to develop the knowledge of nursing assistants in these areas was undertaken. We also saw the skills of nursing assistants developed in other areas, for example nursing assistants on T10 had been supported to develop knowledge and skills in cannulating patients.
- Some staff told us they received regular one to one meetings with their line manager or mentor to guide their development and highlight any learning that was required. Annual appraisal were held and staff told us they were useful for setting goals for the upcoming

year. Appraisal compliance varied between the wards providing medical services; most wards had 90% completion or more (including four with 100% compliance) however two wards (T7 and T8) had lower appraisal completion rates at the time of our inspection with 88.24% and 86.49% respectively.

Medical:

- All staff were required to attend a trust induction within four weeks of commencing employment. This induction covered the core expectations of staff, some aspects of mandatory training and an overview of the trust values and vision.
- Locum doctors were required to maintain their mandatory training such as basic life support via their employment agency. They also received local induction at the start of their first shift on the medical wards.
- Local inductions were completed by peers or other ward staff andspecialist trainee and foundation yeardoctors told us they were well prepared when they started work in the hospital. They told us they were able to seek support from colleagues who had worked in specific areas for longer than themselves.
- In line with the requirement of the deanery training schemes, formal teaching was available to specialist trainee doctors on a training scheme on a weekly basis or more frequently in some areas. Doctors told us they were usually able to attend scheduled training sessions, although this sometimes proved difficult for staff working on AMU due to busy workloads. Doctors not working in a training role were sometimes able to access formal training sessions although this varied according to their role at the time.
- Doctors told us they had access to ad hoc development opportunities through bedside teaching and practical procedure experience. They told us they were not asked to perform tasks that were beyond their level of competence.

Multidisciplinary working

- Board rounds or huddles were held on a daily basis on the medical wards and additional huddles were held to address specific themes, such as discharge. Board rounds were attended by medical and nursing staff, physiotherapists, occupational therapists and social workers. We observed a discharge huddle on T8 which identified patients' estimated discharge dates, the predicted location of their discharge and what steps needed to be taken to achieve discharge at the desired time.
- The team respected the opinions of everyone involved in the patient's care, for example we observed discussion about a patient who was identified as being medically fit for discharge but therapy staff had concerns about the patient's ability to manage at home. It was agreed that a discussion should be held with the patient about the potentially for any ongoing support and a referral made to local care providers once the patient consented.
- Staff on non-medical wards told us it was easy to access the medical team looking after outlier patients on their wards. They told us the team would review patients in addition to their usual ward round if required and would provide additional support to the staff caring for the patient if needed.
- We observed a multidisciplinary morning meeting on AMU and noted that it was unstructured and lacked a systematic approach. Patients were discussed in a random order and other patients were raised before the discussion regarding the previous patient had been completed. We noted that staff were frequently unsure were certain patients were located in the hospital and one patient was discussed fully before a member of staff identified that the patient had died the previous night. During this meeting, there was no representative for the gastroenterology team and staff did not know who would be responsible for those patients over that day. It is recognised that this inspection ran during a period of junior Doctor's strikes, which could have impacted on attendance. We were informed by the trust that the gastro registrar usually attends the triage meeting daily to accept the patients that are triaged from AMU to gastro, however we did not see evidence of this during our inspection.
- Discharge letters were posted to patients' GPs when they were discharged from hospital. Their discharge summary included information about their admission and a reconciled medicines list for the GPs information. Details of any follow ups were included to ensure the GP was aware of the patients' ongoing medical status'.

- We saw evidence of liaison with community teams by therapy and nursing staff on the wards. The knowledge of community teams was used to identify patients' previous levels of function, home and environment and support mechanisms, such as assistance with shopping, which were already in place. This liaison was particularly evident by the therapists working on T7.

- Referrals to community teams were made when patients were discharged with ongoing needs, for example we saw evidence a patient was referred to the district nurses for wound dressing.

Seven day services

- Consultants were available and completed ward rounds seven days per week on AMU, T13S and HASU. On T8, consultants completed a full ward round on Saturdays and reviewed new and unwell patients on Sundays. Consultants were available on call over weekends with the expectation that they come into the hospital if needed on T10 and T14N. Consultants were available on call and completed ward rounds seven days per week on AMU, T13S, HASU, T7 and T10M.

- We reviewed medical outlier patients who were not accommodated on medical wards and saw they were regularly reviewed by their medical team, including at weekends.

- Staff told us that occupational therapy and physiotherapy was not available at weekends, with the exception of emergency respiratory physiotherapy cover which was available 24 hours per day, seven days per week on a bleep referral basis and reviews of patients ready for discharge on AMU. Nursing staff told us they tried to "keep patients moving over the weekends" in lieu of therapy involvement.

- Services such as phlebotomy and diagnostic imaging were available seven days per week and out of hours if needed in an emergency. Staff told us there were no issues accessing these services, although there was always a slight delay for routine investigations due to other demands on the services.

Access to information

- New patient notes were set up for each patient on admission to hospital. Staff told us documentation from old admissions was available on an internal computer system which could be accessed on most computers. This meant staff could access all required information digitally without waiting for notes to be tracked and delivered to the wards.

- We noted some difficulties with accessing information during morning multidisciplinary meetings, for example where there were difficulties accessing the electronic patient list. We also noted inaccuracies in the printed information staff were referring to.

- Multiple care pro formas were used across the medical wards and we observed two different versions of the same document in use for some patients. For example a care booklet containing key assessments, such as falls and pressure ulcer risk, was used however we also saw a separate pro forma for a falls risk assessment completed for the same patient. Staff were unsure which documents should be used and told us the range of documents in use meant they were sometimes unclear about when different assessments needed to be completed.

- Staff had access to policies and procedures via the trust intranet. National guidance and recommendations could be accessed on the internet on most hospital computers.

- On discharge, patient notes remained on the ward until they were sent for coding. Patients using the discharge lounge were accompanied by a handwritten handover sheet which was completed by staff on the discharging ward. Staff in the discharge lounge were unclear how they would know if a patient was not for cardiopulmonary resuscitation should they go into cardiac arrest. The matron for the discharge lounge told us they would accept a handwritten note on the handover form from the ward as notification of a patients' resuscitation status and would not commence resuscitation if the handover form said they should not. Formal 'Do Not Attempt Cardiopulmonary Resuscitation' (DNACPR) forms must be used to identify patients who are not for resuscitation and it is not appropriate to rely upon a hand written handover document for this purpose.

Consent, Mental Capacity Act and DoLS

- Staff were aware of the need to obtain consent from patients to complete a variety of care tasks, for

example to take the patient's blood pressure or to complete a physiotherapy session. We observed staff at all levels asking for patient consent throughout our inspection.

- We saw evidence appropriate consent forms were used within the endoscopy unit and these were usually fully completed. We observed a doctor getting consent from a patient prior to their endoscopy procedure and noted that the doctor fully explained risks and benefits to the patient.
- Endoscopy staff told us translators were used to obtain consent from patients who could not speak English and this was documented on the consent form. During our inspection we did not always see evidence use of translators was documented on the consent forms.
- Mental capacity assessments were completed by doctors on the wards if a patient appeared to lack capacity. Staff understood that patients must be presumed as having capacity until proven that they do not.
- Some staff told us relatives could provide consent on behalf of a patient if the patient lacked capacity, however this was incorrect as a best interest decision should be made in this circumstance. This was correctly identified by most staff.
- Some staff were aware of when 'Independent Mental Capacity Advocates' (IMCAs) should be used and were able to provide appropriate examples of when this had taken place on the medical wards.
- Most staff were familiar with DoLS although not all staff we asked could accurately describe what it entailed or the implications of DoLS in a hospital setting.
- We observed several patients on the medical wards under a DoLS order. The correct documentation for DoLS was seen to be in place including extension applications. Staff told us they almost always needed to apply for an extension due to the availability of DoLS assessors.
- At the time of our inspection there were three patients detained under mental health sections. We noted that one patient had been allowed to leave the ward with supervision which was contrary to what the mental health section stated. Staff were unclear about what mental health sections entailed and one staff member told us "I never know the difference between detaining someone without capacity under DoLS or sectioning them under a section 5".

Are medical care services caring?

Good

We rated caring of medical care services as good because:

- Patient feedback was positive and we saw numerous thank you cards expressing the gratitude of previous patients and their relatives.
- A number of patient feedback questionnaire results also showed patients were happy with the care they received.
- We observed numerous positive interactions between patients and staff.
- Staff provided emotional support to patients and their relatives, as well as signposting them to external support organisations.
- Patients were involved in discussions and decisions about their and were offered opportunities to ask questions and clarify information.

However;

- We noted patient confidentiality was not always fully respected by staff, for example multidisciplinary discussions were held in the corridors with patients and relatives within earshot.

Compassionate care

- The 'Friends and Family Test' (FFT) was given to patients to determine whether they would recommend the medical services provided by the hospital to their family and friends. Results from the FFT were displayed on some wards, although we noted some results displayed were not for the most recent month.

Medical care (including older people's care)

- The response rate for the FFT across the medical wards was slightly lower than the England average. Between January and December 2015, the average proportion of patients who would recommend the medical services provided by the hospital was 95%.
- Patient feedback was complimentary overall, with patients described the medical wards as "second to none" and "my favourite in London". There were many cards on display across the medical wards expressing the appreciation and gratitude of previous patients and their relatives.
- We observed numerous positive interactions between staff and patients, with staff speaking kindly and respectfully to patients and their relatives.
- Patient feedback questionnaire results from January to December 2015 showed between 92% and 96% of patients said that nursing staff attended to their comfort and personal needs as often as they required. These results were significantly better than the 77% trust target.
- Patients told us their call bells were usually answered quickly although they described how staff were often busy and could take "a little while" to come. Most staff tried to answer call bells as soon as possible. However some staff including senior nursing staff and doctors, walked past patients who had pressed their call bell for help without acknowledgement. Some call bells took between seven and eight minutes to be answered.
- The hospital audited data from real-time patient feedback to establish how quickly call bells were answered on the wards. A benchmark score of 72 was set by the trust in line with the 2014 National Inpatient Survey. Between September 2015 and February 2016, AMU was the only medical ward which was consistently above the target. T7 met the target for all but one month and results for the IF unit and T10 were variable. T10M and T8 consistently failed to meet the target.
- Staff information about bereavement procedures was on display in a public area on T14. The public location of this information could cause distress to visitors on the ward who might be visiting an unwell or dying loved one.
- There were surveillance cameras in the endoscopy treatment rooms which displayed activity inside the rooms (including patients undergoing endoscopic procedures such as colonoscopies) on small screens within the patient recovery area. These screens were directly opposite patient recovery beds and could be viewed by anybody walking past the screens, including visitors to the unit. This meant patient privacy and dignity was not maintained during their endoscopy procedure. Staff told us the cameras were in place for safety but it was unclear how safety would benefit as the screens were not formally monitored and emergency alarms were available within all treatment rooms so help could be sought from inside the rooms without the need for the cameras. Additionally, patients were not informed of the camera surveillance during their procedure therefore did not have the opportunity to object to their procedures being displayed on the screens.
- We observed some occasions on the medical wards where patient privacy and dignity was not fully maintained. For example we saw a nurse assist a patient onto the toilet through the door to the bathroom which had been left partially open. We also saw a senior nurse using a commode instead of a wheelchair to take a patient to the bathroom, which did not preserve the patient's dignity.
- Patient feedback questionnaire results from January to December 2015 showed between 94% and 98% of patients said their privacy was maintained during examinations or treatments. Results met or were better than the trust target of 97% during six months in 2015.
- We observed some occasions where patient confidentiality was not fully maintained. For example we saw a staff member referring to a paper handover list when speaking to a patient's relative; the handover list contained personal information about all patients on the ward and was held in plain sight of the relative. Furthermore we observed a discharge planning huddle on T8 which took place in the ward corridor with patients and relatives walking through the meeting when confidential patient information was being discussed.
- We observed a visitor ask a staff member about a specific patient; the nurse gave the visitor a full update

on the patient's wellbeing and ongoing plan and then asked the visitor who he was. The staff member could have given confidential information to the visitor inappropriately as they did not know the visitor's relationship to the patient.

Understanding and involvement of patients and those close to them

- During consultant ward rounds we observed excellent interactions with patients, including clear explanations and checking patient understanding before moving on. However some patients told us they were not aware of the plan relating to their care.
- Medical outlier patients understood why they were not being care for on the type of ward indicating by their condition and told us they knew which consultant was leading their care.
- We observed circumstances when patient opinions were considered and discussed in relation to identifying an ongoing care plan. For example during a medical handover a patient's transfer to a hospital in another part of the country was discussed at the patient's request.
- We observed some occasions when patients were not involved in decision making, for example we saw a member of staff ask a one to one carer if a patient would like soup rather than asking the patient. The patient was able to communicate therefore there was no reason the patient should not have been asked.
- Patient feedback questionnaire results from January to December 2015 showed between 81% and 93% of patients said they were sufficiently involved in decisions about their care and treatment. These results were better than the 80% trust target.
- One patient and their relative described feeling "pushed" into agreeing to take part in a medicines trial by an oncology consultant; the patient told us "I didn't have a choice". They reported not feeling listened to despite raising several concerns about the trial medicine and side effects.
- There were eleven versions of the nursing uniform used to indicate different nursing roles in the trust, including navy blue with several different coloured piping options for senior staff such as matrons, clinical nurse specialists and practice development nurses. We discussed this with staff who acknowledged it may be confusing to patients but said that they would recognise the navy blue uniforms as more senior members of staff. Patients we spoke with had noted the different uniforms and were not clear what any of the different colours meant, including the difference between ward nurses and senior staff. Patients told us the senior ward staff did not introduce themselves.

Emotional support

- Patients told us staff provided emotional support during their admission, particularly when they needed help making decisions about their treatment or discharge options. One patient described how a nurse "spent an hour sat with [the patient] when trying to decide if [the patient] needed to have help at home".
- Staff described an occasion where a husband and wife were admitted to the hospital at the same time but were located on different wards. To help the patients maintain an element of social normality, staff helped the patients to see each other and have lunch together.
- We observed staff asking patients their opinion about various aspects of their care and offering to contact the patients' relatives for additional support if the patient was upset.
- Staff were aware that having a loved one in hospital could be a distressing time for relatives and told us it was "important to support the relatives as well as the patients". They described how they try to develop relationships with family members so the relatives were reassured and confident in the care being provided.
- Patient feedback questionnaire results from January to December 2015 showed between 86% and 94% of patients said they received suitable emotional support from staff during their admission. The results were better than the 85% trust target.
- Staff were aware of external support organisations and told us they would direct patients and their relatives to these organisations if additional support was needed. For example staff on T10 told us they frequently signposted patients to cancer support groups.

Medical care (including older people's care)

- A multi-faith chaplaincy team was available within the hospital to offer spiritual and pastoral care to patients and visitors. Patients told us the support provided by the chaplaincy team was "irreplaceable" and "an invaluable asset".

Are medical care services responsive?

Good

We rated responsiveness of medical care services to be good because:

- Staff recognised the changing needs of the local people and wider population and used a task force to identify and address any gaps in services.
- A range of support teams, such as translators and the drug and alcohol support team, were available to meet patients' individual needs.
- Referral to treatment time data was good.
- The discharge lounge was well utilised and 'pack and go' health care assistants helped to get patients ready to leave the ward to assist with patient flow through the hospital.
- Formal and informal complaints were appropriately handled by staff and patients received full and systematic responses to their concerns.

However;

- There were challenges with flow through the medical wards, which was evidenced by longer than expected AMU stays for some patients and difficulties in accessing HASU care, partly due to medical outliers on the unit and delayed acceptance of patient transfers to other hospitals' stroke units.
- The proportion of patients who moved wards on two or more occasions was low (6%) however these patients were often particularly frail as they were under the elderly medicine or oncology teams.
- We noted a high number of ward moves out of hours and a longer than average length of stay in several areas.
- Patients living with dementia were highlighted by forget me not flowers on the name boards however it was unclear what affect this had on their care in practice. There were various facilities and items provided to assist in the care of patients living with dementia, such as a 'reminiscence room' and puzzles, however we did not see these in use at all during our inspection.
- Ward staff were unaware what support was available for patients with a learning disability and those with profound deafness or blindness.
- There were 25 mixed sex accommodation breaches on the medical wards between September 2015 and February 2016.

Service planning and delivery to meet the needs of local people

- Staff within medical services identified a changing population and acknowledged an increased need for elderly care and general medicine beds within the hospital. Reviews of pathways to facilitate patient access and flow through the services were ongoing and senior staff liaised with community services to ensure a joined up approach.
- Where the needs of local people were not optimally met, staff told us a task force including local stakeholders was implemented to identify and address the gaps in services.
- Patients were provided with a welcome pack on admission to the medical wards. This pack contained a hospital information leaflet, non-slip socks, paper, a pencil and highlighter, an eye mask and ear plugs. Patients told us this pack was useful, particularly the eye mask and ear plugs.
- Between September 2015 and February 2016 there were 25 mixed sex accommodation breaches on the medical wards. This meant male and female patients were cared for within the same clinical area, although staff told us they tried to separate patients with curtains at all times.
- Patient recovery areas in endoscopy were separate for males and females. However staff told us some patients might be recovered in a mixed sex area towards the end of the day due to having less staff on shift at that time. Staff told us patients would always be separated by a curtain if this occurred. Additionally, if a male patient was accommodated in room six in

endoscopy, he had to be moved through the female recovery bay to access the treatment rooms due to the layout of the unit. We observed this take place during our inspection.

- A large waiting room was available at endoscopy reception however we noted the space was very busy and there were not enough seats for patients or visitors at once.
- Visiting was allowed on the medical wards between 11am and 8pm, with protected times scheduled at lunchtime as well as for the evening meal and designated quiet time. A maximum of three visitors at any one time was allowed per patient. This was to ensure it did not become too noisy or busy for other patients on the ward during visiting times.

- Carer passports allowed relatives access to a specific ward during visiting hours without having to use the buzzer entry system.

Meeting people's individual needs

- Patients living with dementia were highlighted on the medical wards via a blue forget me not flower next to their name on the main patient details board. However it was unclear what difference this type of identifier made to patient care and interactions in practice.
- Patients living with dementia were often accommodated together in one bay so a staff member could be allocated to the bay and oversee the patients at the same time. During our inspection we noted there was a table and chairs in the middle of this bay and staff told us they were intended for mealtime use however were rarely used. We did not see patients seated at this table throughout our inspection.
- Staff did not always use effective methods to meet the needs of patients living with dementia. We observed a patient frequently trying to stand up and staff were concerned this placed the patient at risk of falls. We observed the staff member stand over the patient and repeatedly tell the patient to sit down without providing any other distraction or activity to help the patient settle. Later on, we observed a different member of staff help the patient style their hair and bring them a birthday cake.
- A range of facilities (such as a 'reminiscence room', 'noughts and crosses' games, china tea cups with two handles and a range of puzzles and books) were available for older patients and those living with dementia on T7 and T10 (elderly medicine). However we did not see these facilities in use during our inspection.
- There was no specific identification or support system in place for patients with a learning disability or those who were severely blind or deaf. Staff were unsure how the care of these patients would be supported in the hospital and told us they would seek advice from senior colleagues.
- Staff told us translators could be booked for face to face or telephone translation sessions and we saw evidence they were used to get patient consent prior to procedures and for specific discussions. A patient living with dementia on T7 did not speak English as a first language and staff told us they had little interaction with them because of the language difficulties.
- A range of menus were available to meet the needs of patients and these were also available in large print and with pictures to assist patients in making their food selection.
- Patients with a history of drug or alcohol abuse could access an alcohol and drug liaison team who would support them during their admission and liaise with community services regarding their drug and/or alcohol misuse on discharge.
- A psychiatric liaison team was available to assist staff in caring for patients with specific mental health needs. This team was available to make mental health needs assessments to provide expertise for managing complex mental health patients, for example those under a mental health section.
- Chaplaincy facilities were available within the hospital and included a Christian chapel, Muslim prayer room, Jewish Sabbath room and a multi-faith quiet room. These facilities were open to patients and visitors 24 hours per day.

- We observed volunteers working across the medical wards; chatting to patients and asking them if they needed any shopping from a supermarket done on their behalf. The volunteers approached each patient individually and took a note of their requests.
- A therapy dog visited T7 on a weekly basis and staff told us patients liked the novelty of having a dog on the ward. They said the therapy dog had a particularly calming influence on patients with confusion but was also appreciated by staff members too.

Access and flow

- Patients accessed the medical services after becoming unwell at home and being admitted via the emergency department or through booked admissions for planned treatment. Most patients who were admitted were non-elective admissions who were usually admitted onto AMU first.
- The AMU comprised of 56 beds; 41 beds were used as an acute assessment model of care with a target stay of less than 72 hours and 15 beds were allocated as acute frailty beds with a target length of stay less than 5 days. The average length of stay on AMU was 2.3 days between November 2015 and January 2016. However, during our inspection we saw some patients had been accommodated on the unit for many more days than expected, including one patient who was on day nine of their AMU admission.
- The average length of stay for non-elective general medicine and neurology patients was less than the England average, however length of stay for non-elective geriatric patients was longer. The average length of stay for elective gastroenterology patients was slightly longer than the England average and much longer for medical oncology patients.
- Between December 2016 and February 2016, there were 505 patient outlier episodes (where patients were on a ward not specific to their medical needs). Most outlying patients were general medical (131) or stroke (70) patients.
- Staff said outlying patients received optimal care during their admission; however they highlighted that HASU accommodated non-HASU patients which led to access difficulties for patients with hyper-acute strokes. During our inspection we noted that a hyper-acute stroke patient was admitted to AMU but was not able to be transferred to HASU as there was no free bed due to medical outliers. One consultant expressed concern that this patient's care had been compromised as the patient would not receive specialist stroke care on AMU. Hospital data showed there were ten outlying patients on HASU between September 2015 and February 2016.
- Between December 2014 and November 2015, most medical patients (72%) did not move wards during their admission (non-clinical bed moves). Some patients (22%) moved ward once and 6% of patients moved ward twice or more. Most patients who moved ward twice or more were geriatric medicine or medical oncology patient who were therefore likely to be frail. Of the patients who moved ward four or more times, 34% were aged 80 years or older.
- Between July and December 2015 there were 885 patients moved from medical wards after 10pm; this averaged 147 patients each month. Most of these patients (60%) were moved from the AMU.
- Staff told us patients should be admitted to HASU for up to 72 hours however patient transfers out of HASU to rehabilitation units was difficult due to rehab bed availability and had a knock on effect for patients trying to access the HASU service. Staff illustrated their concerns by highlighting a patient who had been on the unit for over 7 days.
- The trust target aimed to have completed 35% of patient discharges by 11am each day to improve patient flow through the hospital. The medical specialties division achieved between 11.8% and 20.3% from November 2015 to January 2016.
- Between September 2015 and February 2016, there were 517 patients discharged from the medical wards between 10pm and 8am. Most of these (250) patients were discharged from AMU. Hospital staff told us these discharges occurred for various reasons, including patient choice.
- Some wards had allocated 'pack and go' nursing assistants who helped patients being discharged to wash and dress as a priority over other patients on the ward and assisted them to pack their belongings. They also escorted patients to the discharge lounge if required.

- Some patients were moved to the discharge lounge prior to going home from hospital. To be eligible to use the discharge lounge, patients had to be mainly self-caring and ambulant. Staff in the discharge lounge told us most patients (60%) were in the facility for less than one hour while waiting to go home.
- The trust met the 18 week referral to treatment time target across all specialties from February 2015 until May 2015, when the target was abolished. Between May 2015 and February 2016, the trust continued to perform better than the England average. The trust met the standard in 7 out of 8 specialty groupings with only cardiology not meeting the standard (September 2014 to August 2015).
- Patients were usually referred for endoscopy procedures after an outpatient appointment with a relevant consultant. Inpatients could also be referred for emergency endoscopy.
- At the end of November 2015, there were 213 patients overdue their endoscopy procedure, including 162 patients who had a procedure date booked and 51 who did not. This was an improvement from October (232 patients overdue) and September 2015 (256 patients).Staff told us the complexity of patient needs meant there were sometimes delays in organising procedures. Additionally, some patients chose to delay their procedure. Non-compliance with diagnostic wait times was recorded on the risk register in March 2013 and remained as an identified risk at the time of our inspection.
- Hospital statistics showed 70% of routine endoscopy patients were seen within six weeks in February 2016. This was better performance than January 2016 (62%) but worse performance than in December 2015 (93.6%).
- Hospital statistics showed 59% of urgent endoscopy patients were seen within two weeks in February 2016. This was slightly better performance than in January 2016 (57%) but slightly worse than in December 2015 (63%).
- To reduce the backlog of endoscopy patients, the unit was performing endoscopies six days per week with the unit open from 8am to 8pm.
- Staff told us patients waited for 20-25 minutes before their procedure and this was monitored on a monthly basis. Patients said their waiting time was reasonable and told us staff updated them about the waiting time.
- The 'did not attend' (DNA) rate at endoscopy was 4% in February 2016 which was worse than in January 2016 (2%) and December 2015 (3%), although was still lower than the target (5%). Staff told us patients received reminder letters to try and reduce the number of DNA patients and therefore wasted endoscopy treatment time.
- Room utilisation in endoscopy was 93% in February 2016, 90% in January 2016 and 90% in December 2015. This level of utilisation met the trust target of 90%. Senior staff told us between 60 and 80 patients were seen in endoscopy each day.

Learning from complaints and concerns

- The charge nurses managed informal complaints at ward level and escalated to the relevant matron if needed. Some wards documented all informal complaints and negative feedback and were able to demonstrate some changes to practices as a result of this.
- For more serious complaints, patients were directed to the patient advice and liaison service (PALS) within the hospital. Leaflets advertising PALS were available at the reception desk of some wards. We also saw that some wards had additional posters advertising the contact details for PALS, however this was not evident on all medical wards.
- We saw evidence of formal complaint responses which systematically addressed each point of the complaint made. The responses outlined the investigation which had taken place and any points for improvement that had been identified. Complaint responses also included apologies.
- Patients told us ward staff were receptive to their feedback and took their complaints seriously. They told us staff "did what they could" to immediately address any concerns raised and also brought issues to the attention of senior staff.

Medical care (including older people's care)

- We observed a staff member in endoscopy managing a patient's complaint. The staff member was sympathetic and helpful to the patient concerned, and ensured a suitable outcome was achieved.

Are medical care services well-led?

Requires improvement 

We rated leadership of medical care services to be requires improvement because:

- The risk register provided to us by the trust did not contain some risks we identified during our inspection, for example risks relating to medicines administration. We also saw the register was not always appropriately used or updated; for example no documented review of the falls risk between September 2013 and May 2015.
- We saw evidence to suggest that learning from incidents was not communicated consistently and on-going reviews of practice by senior staff in relation to this did not occur, such as the poor completion of the SSKIN documentation.
- There was an apparent disjoint between ward and senior staff with regards to governance; junior grades were not engaging in governance activity and senior staff were not aware of this.
- There was little evidence of staff engagement, including in the development of the nursing strategy.

However;

- Staff were confident in the leadership team and told us they were approachable and visible.
- There was a positive culture on the medical wards and staff told us they enjoyed their work.
- We saw evidence of some innovations, such as involvement in published research articles and a new 'Frailsafe' system to instigate conversations between junior and senior staff when concerned about a patient.

Vision and strategy for this service

- A strategy document outlined the planned development of the medical services over the next five years. However, ward staff were unsure of how their own area of the hospital was aiming to develop and told us the management teams worked on this type of strategic planning. They told us they completed their day to day tasks without considering how it contributed to the longer term vision or strategy of the organisation.
- A new nursing strategy was recently developed in the trust and was due to be implemented around the time of our inspection. Staff at matron level and above were aware with the development of this strategy however staff working below the level of the matron were unaware of this and told us they had not been involved any discussions regarding its development.
- Some staff were aware of the trust values and could describe how these contributed to their daily work however others could not identify any.

Governance, risk management and quality measure

- Staff told us governance meetings were held on a monthly basis and attendance from charge nurses, matrons and management was expected. One charge nurse told us attendance at governance meetings was usually poor due to other conflicting activities on the wards and that they had "not been to [a clinical governance meeting] for months".
- Senior staff told us access to governance meetings was encouraged for junior staff however none of the junior staff we spoke with were aware of governance meetings and did not know if they were supposed to attend. Some junior staff told us they were disconnected from governance processes. Attendance registers for two elderly medicine and two AMU governance meetings showed no nursing staff below the level of a charge nurse or ward sister attended and just two doctors represented the medics below consultant level.
- Some ward areas held monthly meetings but in other areas senior staff told us there were no formal meetings and they would "feedback information when [they] see people". This meant there was no formal documentation of discussions held or which members of staff had received the necessary information.
- The results of root cause analysis from one serous incident indicated poor completion of the SSKIN care

bundle contributed to a patient's grade three pressure ulcer. The action plan from this included teaching and improvement in the completion of this care bundle however we reviewed many SSKIN assessments which had been incorrectly or only partially completed, indicating the actions from the root cause analysis had not been successfully implemented.

- Some senior staff were unclear about the safety performance on their own wards. For example one senior staff member was not aware of the ward's performance with regards to pressure ulcers and falls. Another senior staff member was unable to identify any learning which had occurred following medicines errors on their own ward.
- Potential risks for the medical services were recorded on risk registers which spanned the cancer, emergency services, gastroenterology services, infection and medical specialities divisions. This was due to the divisional structure in use within the hospital. The risk registers for the medical wards reflected most risks we identified during our inspection, however certain issues such as risks relating to medicines due to the use of paper and electronic prescribing systems on AMU were not identified.
- We were concerned at the lack of governance and risk oversight of cameras which displayed patient procedures on screens in the recovery area.
- Some items remained on the risk register for a long time; for example the risk of falls in elderly care was placed on the register in March 2011 with a projected completion date for actions identified as June 2013. A number of actions were completed to address the risk however it remained on the register at the time of our inspection. We noted there were no reviews of this risk recorded between September 2013 and May 2015.
- Results from the SSNAP audit were reviewed at 'Clinical Audit & Quality Improvement Committee' (CAQIC) meetings and we saw evidence that each component part of the SSNAP rating was considered so any required improvements could be identified and actioned.
- In oncology monthly audit presentations and workshops were held to provide learning and development opportunities for staff.

Leadership of service

- Clinical leadership of the medical services was provided by two clinical directors; one who covered the urgent care division, encompassing AMU, and one who was responsible for the other areas of medicine. They were supported by clinical lead physicians at service level.
- Nursing leadership was provided at a ward level by a team of matrons and charge nurses who led and supported staff during their day to day activities. Staff working at charge nurse level and above were supernumerary and were not counted in ward nursing numbers which meant their roles were dedicated to the development and quality monitoring of their service.
- The medical services leadership team were skilful and knowledgeable staff, with sufficient experience to lead care on the medical wards. However we noted that one charge nurse did not had the relevant competencies to provide clinical support to staff on the ward as their nursing background had not involved this specific skillset.
- Staff were confident in the medical services leadership teams and told us they received good support from their senior colleagues. They said all levels of nursing leadership were highly visible and approachable on the wards. Staff believed the leadership team understood what challenges staff faced on a day to day basis and could relate to their difficulties.
- The opinions of staff at all levels was welcomed by senior staff within the medical wards, for example we observed a foundation year doctor raising a concern with a consultant about a patient's mental capacity and this concern was fully considered and respected.
- Junior medical staff told us they had raised concerns within the trust about the number of hours worked over specific periods. This was taken on board by the leadership team who were monitoring and assessing the number of hours worked by individuals.
- Staff told us some members of the trust leadership team such as the Director of Nursing were visible around the hospital and approachable, but others were less frequently seen on the wards.

Medical care (including older people's care)

Culture within service

- Staff described a "no blame" culture and told us they were encouraged to report clinical incidents. Staff believed there was a proactive culture in learning from incidents and sharing this information, however staff were largely unable to identify learning from any recent incidents when asked.
- The leadership team were concerned with the well-being of their staff. Staff told us they had been offered additional support at ward level and formal counselling in relation to the deterioration of a long-stay patient who many of them knew well.
- Staff told us they were valued by more senior staff and the medicine leadership team. We saw evidence of investment of staff skills, including at nursing assistant level, and staff told us they were supported with development opportunities and encouraged to aim for more senior roles within the organisation.
- Staff described how their professional opinions were respected by their seniors and their efforts were appreciated; however we observed a situation where a junior member of staff was openly and repeatedly criticised by a consultant during a multidisciplinary meeting on AMU.
- Staff enjoyed their work and told us this was partly due to the "fantastic" teams they worked in. They told us they worked together and would "muck in" to help one another out, for example answering call bells in each other's bay if their colleague was busy. In practice we observed this particular example did not often occur and we observed staff, including members of the leadership team, ignoring patient call bells for long periods.

Public and staff engagement

- Questionnaires were used to get feedback from patients and their families regarding their experienced of care within the medical wards at the hospital. Senior staff analysed the results and told us they used team huddles and meetings to provide feedback to ward staff regarding areas that required improvement and areas where performance had been good. However, most ward staff told us they did not recall receiving feedback about these questionnaires.
- Ward safety and quality boards had space for "you said, we did" which was the method used to display what actions had been taken in response to patient and relative feedback. On most medical wards we visited, this space did not display public engagement as it had been left blank or covered with a different document such as one providing staff with information about the inspection process. On AMU we noted this section of the board was used appropriately to identify patient feedback and the actions put in place to address the feedback.
- Patient and relative feedback was used to guide changes and measure the success of the 'Mealtimes Matter' project which aimed to improve the experience of older patients at mealtimes. . This included changes such as delaying lunchtime so all medical teams had completed their patient reviews before the protected time and ensuring staff were nominated to assist patients with eating.
- A trust-wide awards ceremony was held annually at a nearby venue and was used to identify individuals and teams who had performed beyond expectations or who had accomplished specific achievements. The matron and team on T7 won the trust's Kate Granger Award as well as the 'Top Quality Patient Care' award for their 'Mealtimes Matter' project in 2015.
- 'Tea with Matron' was held on a monthly basis on T7 so patients and their relatives could spend time speaking to the matron about their experiences on the ward. Posters advertising this identified this as an opportunity to share ideas about how the ward could be improved.

Innovation, improvement and sustainability

- The AMU noticeboard indicated that the unit was taking part in a new national safety checklist for older people on AMUs called 'Frailsafe'. The list was designed to be a 'check and challenge' list triggering interaction between a senior doctor and another member of staff, such as a staff nurse.
- Various research had been completed by members of the endoscopy team and we saw evidence of published articles in journals such as the 'World journal of Gastroenterology', 'Endoscopy' and 'Gut'.

Medical care (including older people's care)

- The specialist training and development of nursing assistants as 'specials', including the creation of a warning system to highlight when patients were becoming unwell, was a key improvement in the care of patients on T8.
- In order to reduce the amount of time patients spent in the endoscopy unit, a trial of posting bowel preparation medicines to colonoscopy patients at home was due to begin following our inspection. Staff told us this would mean a greater number of patients would be able to access the service each day and this would improve the patient waiting list.
- Senior staff consistently identified staffing as a risk to the sustainability of the medical services within the hospital. They described difficulties with recruiting and retaining staff and identified steps in place to address these issues, for example the "refer a friend" initiative where staff received a financial reward for successfully referring a friend for a job.

Surgery

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

Information about the service

University College London Hospitals NHS Foundation Trust provides elective and emergency surgery services to both the local populations of Camden, Islington, Barnet, Enfield, Haringey and Westminster and to patients from across England and Wales.

Most general surgery at UCLH is undertaken at the main UCH site. At UCH elective, emergency and day case surgery are provided. T6 has 21 beds and is a dedicated head and neck surgery ward, T6 North short stay (accommodating all surgical short stay patients) has 23 beds, T6 gynae has 15 beds and is a dedicated ward for women's health. General surgery long stay patients go to T9 which has 62 beds. T9S and T13S are dedicated gastrointestinal surgery wards . T10S is a dedicated trauma and orthopaedic ward with a minimum of 8 ring-fenced elective orthopaedic surgery beds

Elective urology (26 beds + 18 short stay) and thoracic surgery (23 beds) are carried out at UCH at Westmoreland Street (WMS). Paediatric day case dental surgery is undertaken in the UCH Macmillan Cancer Care unit. There are pre-assessment clinics and a gender separated surgical reception unit. Interventional Radiology is undertaken in the hybrid theatres at UCH. The day surgery unit comprises of two operating theatres and a ward located on level T2 of the main UCH site. .

The main theatres suite at the UCH main site is made up of 12 operating theatres, and is located on level P3 of University College Hospital.Facilities include a dedicated adult and paediatric recovery area. The department comprises of 150 theatre practitioners, 50 theatre support assistants, and a dedicated play specialist delivering perioperative care for over 220 sessions each week. The theatre department at the WMS site had seven theatres.

Between March 2015 and February 2016, 30,692 patients attended the hospital for surgical services; 41% of these were day case surgeries, 40% were other planned elective surgeries requiring hospital stay and 19% of these were emergencies. The largest surgical specialty (in terms of patient numbers) was urology with 10,600 procedures performed.

We last inspected the service in January 2014 and found there were no breaches of regulation but some improvements were needed. The WHO five steps to safer surgery checklist was not always completed. Lack of capacity in theatre recovery affected patient flow through theatres and there were large numbers of cancelled operations due to the overrunning of theatre lists.

Surgical activity at UCLH is managed within four of the divisions which are managed by the surgery and cancer board. These are the cancer division, gastrointestinal services division, surgical specialties division and theatres and anaesthesia division.

We inspected the perioperative care pathway at both the main UCH site and UCH at Westmoreland Street. We followed the patient journey from admission, through operating theatres and immediate post-operative recovery then onto surgical wards until discharge. We looked at the services provided for both inpatient and elective day case patients.

Surgery

During our inspection, we visited the surgical admissions area, the surgical wards, the day surgery unit, main operating theatres and the adult and paediatric recovery area at the UCH main site. We visited the short stay surgery ward, the urology ward, the thoracic ward, and the operating theatres at WMS. In addition to this we interviewed service leads and matrons from each of the surgical divisions and attended multidisciplinary team meetings. We spoke with over 50 members of staff including managers, doctors, nurses, allied health professionals, health care assistants and admin staff. We spoke with over 20 patients and their family members. We observed their care and treatment and looked at over 23 care records. In addition to this, we reviewed local and national data and performance information about the service.

Summary of findings

We rated the surgery service at UCLH as 'Good'. This was because.

- Staff demonstrated good knowledge of the process of reporting; investigating and learning from incidents. We saw good evidence of local and trust wide learning from incidents that had occurred.
- There were on-going improvements in the use of the World Health Organisation (WHO) five steps to safer surgery checklist. Staff demonstrated that this was embedded in their practice and audit data demonstrated this was carried out to a high standard.
- There was good multidisciplinary team (MDT) working between doctors, nurses and other allied health professionals throughout patient pathways.
- We saw staff treating and caring for patients with compassion, dignity and respect. Patient and relative feedback was positive.
- Patient outcomes were monitored through internal and external audits and benchmarked against other services. There was a strong focus on improvement from all levels of staff when results were less them optimum.
- Staff treated and cared for patients in line with local and national guidance and used enhanced recovery pathways where appropriate.
- Matrons and senior ward sisters were visible on the wards and demonstrated strong leadership within their services. Managers were available and approachable and staff felt supported within their work and personal development.
- There were comprehensive governance and risk management processes in place. The trust board's risk register was updated regularly and reflected current risks to the service.

However

Surgery

- Staff raised concerns about staffing levels on some of the surgical wards and we saw incidents where this had affected patient care: for example delayed medication doses.
- Although there was a clear cancer strategy in place, staff were unclear about the vision and strategy for the other surgical services.

We rated safety in surgery to be good because:

- Staff were encouraged to raise concerns and report incidents and near misses; they were fully supported when they did so. Learning from incidents was a high priority and was based on thorough analysis and investigation.
- There were safety systems in place that were embedded and monitored effectively to ensure continuous improvement. The World Health Organization (WHO) five steps surgical safety checklist was well-embedded in theatres and we saw evidence of constant learning and improvement.
- There was good overall safety performance on wards. Safety thermometer information indicated that patients were protected from avoidable harm.

We rated effective in surgery to be good because:

- Patient care and treatment was planned and delivered in line with current evidence-based guidance, best practice standards and legislation. This was monitored on a regular basis to ensure consistency of practice across the services.
- Patients had comprehensive need-based assessments, which included consideration of clinical needs, nutrition and hydration, and their mental and physical health and wellbeing. These assessments guided and identified care and treatment plans. These plans were regularly reviewed.
- The service participated in relevant local and national audits. This included clinical audits and other monitoring activities, such as benchmarking and peer review. Accurate and up-to-date information about audit results and patient outcomes was shared internally and was used to improve care and treatment.
- Continuing professional development was given high priority Staff were proactively supported to acquire new skills and to develop within their roles.
- Consent to treatment was obtained in line with current legislation and guidance. Patients were supported to make decisions. When people lacked capacity to make a decision, 'best interests' meetings were held. The use of restraint was understood as a last resort, and the least restrictive options were always used.

We rated caring in surgery as good because:

- Feedback from patients and their relatives was overwhelmingly positive about the treatment they received from staff. Patients reported the care they had received exceeded their expectations and that they would recommend the service to others.
- We observed staff treating patients with with dignity, respect and kindness during all interactions.
- Patient's emotional and social needs were consider by staff and were embedded within their care and treatment pathways.

We rated responsive in surgery as good because:

- There was a proactive approach to understanding the needs of different groups of people, including those who were vulnerable or who had complex needs. Staff demonstrated how they delivered care in a way that met these needs.
- Patients were encouraged to raise concerns or complaints and we saw evidence that these were responded to in a respectful and timely manner.

We rated well-led in surgery as outstanding because:

- There had been recent reconfigurations of surgical services at the UCH main site and at UCH at WMS. However, staff at all levels demonstrated they were proactively engaged and involved in the changes. Management teams ensured that the voices of all staff were heard and acted on during this time.
- The leadership of the service actively promoted staff empowerment to drive change and improvement. Staff are encouraged to take ownership of their roles at all levels to ensure any concerns could be voiced.

Surgery

- There was a strong focus on continuous learning, development and improvement for all levels of staff.
- Clinical and operational information was collected and analysed. This was used proactively to identify where improvements were needed.
- There were comprehensive governance and risk management processes in place, which functioned effectively from board level downwards. Junior staff members demonstrated a clear understanding of these.
- There was a clear 2015-2020 cancer strategy in place based on outcomes, research, experience and workforce. UCLH is part of the national cancer vanguard working with other organisations to improve cancer pathways for patients.

Are surgery services safe?

Good

We rated safety in surgery as good.

- Staff were encouraged to raise concerns and report incidents and near misses; they were fully supported when they did so. Learning from incidents was a high priority and was based on thorough analysis and investigation.
- There were safety systems in place that were embedded and monitored effectively to ensure continuous improvement. The World Health Organization (WHO) Surgical Safety Checklist was well-embedded in theatres and we saw evidence of constant learning and improvement.
- There was good overall safety performance on wards. Safety thermometer information indicated that patients were protected from avoidable harm.

However

- Staff voiced concerns about low staffing numbers on some of the surgical wards. They were concerned that this resulted in delays in administering medication. We saw some patients whose medication was not given on time and patients told us it took a long time to answer call bells.

Incidents

- The surgery service reported five never events between December 2014 and November 2015.Never events are serious incidents (SIs) that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- There were 15 SIs between October 2014 to September 2015. These SIs included four surgical invasive

procedure incidents, four pressure ulcer incidents, two incidents involving slip/trips, one allegation against a healthcare professional, one maternity/obstetric incident and three other incidents.

- In discussion with senior leadership teams, we were told that over the last year, there has been a strong focus on timely investigations and learning lessons from 'Never Events' and serious incidents.
- We looked at three serious incident reports. These included a detailed chronology of events a thorough investigation and root cause analysis of the incident. They also included discussion of duty of candour, recommendations for immediate and future action and arrangements for sharing these recommendations, learning and actions locally and across the trust.
- Data provided by the trust demonstrated that the trust were now 100% compliant in carrying out the WHO safety checklist for every patient undergoing a surgical procedure. However it was noted that the quality of the checklist can sometimes vary. Distractions and interruptions were observed in 37% of 'Time Out's and 43% of 'Sign Out's. This was recognised as an area requiring improvement which could prevent incidents. As a result, observation audits of the WHO surgical checklist in theatres were carried out to ensure its use and that the theatre team was communicating well. The observational audit focused on all five steps of the checklist measuring the quality of leadership, teamwork, and team engagement throughout the 'team brief', 'sign In', 'time out', 'sign out' and 'debrief'.
- Action plans arising from learning from previous incidents were in place to improve patient safety. For example, scrub nurses were now able to record extra equipment as the recording white board now allowed for flexibility in this respect. Nurses told us that before this change there was nowhere to record supplementary equipment which had led to an incident involving missing needles.
- Staff across the service were able to tell us how to report incidents. They could identify situations requiring completion of an incident form. Staff told us there was a good reporting culture and that they were encouraged to report 'near miss' situations in addition to incidents that had occurred. Staff felt they had adequate time to complete incident forms when required. They felt well-supported by senior members of the team when incidents occurred and needed to be reported.
- Feedback from incidents was demonstrated to be a high priority throughout surgical services. Examples of feedback mechanisms included email, safety huddles, newsletters and handovers. We were also informed about the surgical safety bulletin newsletter, which had recently been re-named 'At the Sharp End'. This newsletter aimed to reduce surgical harm and create a safer teamwork culture throughout the trust through the sharing of lessons learnt from incidents, good practice and near misses.

Duty of Candour

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Staff across the surgical services were able to identify and describe the principles relating to Duty of Candour requirements. Staff we spoke with described the process as: apologising for any mistakes, being open and honest and involving patients and relatives in the investigation process that followed. We also noticed posters on the wards reminding staff of these principles.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections, falls with harm to patients and Venous Thromboembolism (VTE) incidence. Safety Thermometer data was available at the entrance to each ward and was updated daily to demonstrate the number of days of harm-free care.
- Data provided demonstrated that from October 2014 to September 2015 there were five pressure ulcers reported, no falls with harm to patients and four catheter-associated urinary tract infections. Harm-free care was documented from July 2015 through to September 2015.

- During inspection we noted that all patients with a urinary catheter in place had a catheter passport to record the insertion date, batch number, review dates and space to document any issues of concern.
- In theatres, we saw warming blankets and observed fluids were warmed prior to administration. Pressure-relieving equipment including mattresses and limb protectors were available on the wards. Safer skin care bundles, which demonstrated patients turning schedules, were fully complete. Care staff were able to demonstrate the importance of care rounds and correctly described how to assess patients' skin.
- The National Institute for Health and Care Excellence (NICE) recommends that all patients should be assessed for the risk of developing venous thromboembolism (VTE) on a regular basis. VTE assessments were fully completed in all patients' notes we looked at. Audits carried out on VTE assessment demonstrated that the surgical speciality wards were not meeting the trust target of 95%. To improve this staff told us they were encouraged to bring none completed assessments to the doctors attention and theatre staff informed us patients must have these assessments fully completed before being brought for surgery.

Cleanliness, infection control and hygiene

- Infection prevention and control at both the UCH main site and UCH at WMS was well managed. Clinical areas we visited were visibly clean, tidy, well organised and clutter-free.
- We looked at the cleanliness of several pieces of equipment including monitors, syringe drivers, portable suction devices, fluid warmers and infusion pumps.. Equipment sampled was visibly clean and dust-free in most areas. We noticed "I am clean" stickers used in the sluice areas to demonstrate when the equipment had last been cleaned. However, in the UCH main theatre recovery area we saw fluid warmers with "I am clean" stickers on, which were not clean. We saw other equipment with these stickers on which had not been dated.
- Domestic housekeeping staff worked during the day and at night and were provided by an external company. Cleaning staff on ward T09 explained their work was audited weekly. They received regular feedback which noted areas which required improvement.
- Ward areas and theatre departments had infection prevention control (IPC) liaison nurses who linked directly to the IPC hospital team. The IPC hospital team carried out regular spot check audits in all areas of the hospital and gave feedback to the ward link nurses.
- Hand hygiene audits were completed monthly and results from November 2015 demonstrated over 90% compliance for all of the surgical services ward areas.
- Hand Hygiene training was mandatory and data provided demonstrated that 99% of nurses working within surgical services had completed this training. The rate of training for doctors in all surgical services was below the trust target. In the surgical specialities division, 80% of doctors had completed this training.
- Surgical site infection data from July – September 2015 demonstrated a higher than the national average surgical site infection rate for colorectal surgeries (in large and small bowel), long bone and total knee replacement. Staff within the surgical specialities had worked through root cause analysis for each patient's journey to identify areas of IPC improvement. Changes which had been implemented since the publication of this data that we saw during inspection included: strict refusal to allow access to theatres in outside clothes, all name badges to be worn on clips and not worn around the neck, adjustments to the orthopaedic theatre and also monitoring of staff behaviour including staff flow in and out.
- Ring-fenced infection-free orthopaedic beds were provided on ward T10. These beds were only used for post-operative orthopaedic patients who had a fully negative infection screening result.
- All elective patients undergoing surgery were screened for Methicillin Resistant Staphylococcus Aureus (MRSA) and procedures were in place to isolate patients where necessary, in accordance with infection control policies.
- There was easy access to personal protective equipment (PPE) such as gloves and aprons. Staff demonstrated good hand hygiene practices and good use of PPE. We noted all staff adhered to the bare below the elbows guidance in clinical areas.

- Waste segregation and storage was noted to be in line with the Department of Health (DoH) 2011 safe management of waste guidelines. We saw posters advising staff of these guidelines.
- Infection prevention and control posters were prominently displayed throughout wards, corridors of the hospital and in theatres. This included hand hygiene instructions and advice on how to prevent infections.

Environment and equipment

- The majority of wards at both the UCH main site and WMS site appeared bight and clutter free. However, bed spaces on ward T09 appeared cluttered with patient belongings, food and drinks. There were concerns that this would hinder access to the patient in an emergency or prevent adequate cleaning of the bed spaces.
- The theatre department at the UCH main site appeared cluttered with equipment, beds and trollies in the corridors. We observed theatre assistant staff having to move equipment to ensure they could get through with patients on beds and trollies.
- At WMS the building is not purpose built and modifications had been introduced since it was a cardiac hospital. We noticed a lack of anaesthetic space in the first floor theatres. Action had been taken to ensure patient privacy with screens. There had also been some concerns raised over the storage of medication in this area; however, medicine cupboards had recently been installed to mitigate this risk.
- There was a lack of storage space in the recovery area at WMS. This had led to two of the recovery bays utilised for the storage of equipment. There were currently enough recovery bays to accommodate patients however, the hospital was not yet working to capacity and concerns were raised that when capacity did increase, this may cause delays.
- We saw resuscitation equipment available in all clinical areas with security tabs present and intact on each. Systems were followed for checking resuscitation equipment. We saw checklists completed daily with no omissions.
- There were two difficult airway trollies located in the main theatre department at the UCH main site. These trollies were stocked with appropriate equipment. Daily check lists for each of the trollies had a number of omissions. In January 2016, there had been 19 omissions and in February there had been six. Intubating scopes were available. Staff told us there were no concerns around scope availability as staff would send them straight for sterilisation after use.
- In theatres, we saw the Association of Anaesthetists of Great Britain and Ireland safety guidelines 'Safe Management of Anaesthetic Related Equipment' (2009) were being adhered to. Anaesthetic equipment we looked at in theatres nine, ten and three was checked on a regular basis with appropriate logs being kept.
- Single use equipment such as syringes, needles, oxygen masks and suction tubes were readily available and stored in an organised, efficient manner in the anaesthetic and recovery rooms at both the UCH main site and WMS locations. Staff told us about recent improvements that had been introduced to standardise equipment storage across the different anaesthetic rooms. Improvements had also been made in the paediatric theatres and theatre staff were working with staff from the emergency department to ensure equipment was standardised across the departments.
- A range of equipment sampled throughout the wards and the theatre department had dated portable appliance testing (PAT) stickers. A date for the next service was identified on each item. Equipment sampled included monitors, syringe drivers, ECG machines, portable suction devices, fluid warmers and infusion pumps.
- Staff in the theatre department at the main UCH site told us there had been on-going concerns with patient trollies as some were over 10 years old. Staff informed us theatre lists can become delayed as working patient trollies are not always available. This was on the department's risk register.

Medicines

- Medicines, including controlled drugs (CDs), were stored and managed appropriately, were securely locked and checked daily on all surgical wards and in theatres.
- We observed three members of nursing staff distributing medicines to patients. We noted that nurses enquired about allergies and confirmed the patient's name and date of birth before distribution of the medication.
- Pharmacists completed daily ward rounds Monday – Friday and provided on-call cover at weekends. In

theatres there was a senior pharmacist available Monday – Friday who had been in post for fifteen months in order to improve safety through medicine management in the department.

- We saw pre-labelled syringes in two of the anaesthetic rooms in main theatres. Staff told us that this was a consistent problem and there was a resistance to change this practice. This practice is not in line with National Patient Safety Agency (NPSA) safety guidelines.
- The trust had recently implemented a new electronic prescribing and medicines administration (EPMA) system. Nurses were mostly positive about the system and told us that prescriptions were easier to read. However, some nurses commented that the system could cause delays when two nurses had to log-in separately to administer medication such as intravenous or controlled drugs.
- Appropriate antibiotic stewardship was supported by the EPMA system as every antibiotic prescribed had to include an indication, stop and review date as part of the prescription.
- We were told that newly qualified nurses had to pass a competency assessment before administering medicines independently.
- Staff were aware of how to report medication incidents and how Duty of Candour may apply. Learning from medication incidents was shared at safety huddles and within a monthly newsletter.
- We looked at five EPMA records on T10S. Two showed delayed doses of medication – one of these was rectified when brought to the nurse's attention but was given three hours late. There was also a patient whose medication was prescribed to be administered at 08.00 with breakfast. However, the medication had been administered at 06.00 each morning without food.
- Fridge and pharmacy room temperatures were monitored daily on most wards. The long stay urology ward at WMS had multiple omissions in the recording of fridge temperature. Some wards had only started recording minimum and maximum temperatures from 1 March 2016.

Records

- We looked at samples of medical and nursing records on the surgical wards and in theatres. The hospital used mainly a paper based system of recording care, treatment and surgical interventions. EPMA was utilised at the main UCH site only and had not been implemented at WMS. In general, both nursing and medical records were accurate, fit for purpose, stored securely and completed to a good standard.
- Patient records were kept in trolleys in wards areas. These trollies were not locked however were fully visible to staff. Posters around the wards and hospital reminded staff to keep notes in safe places and to ensure notes could not be overlooked whilst in use.
- The World Health Organisation (WHO) five steps surgical safety checklist is a system to safely record and manage each stage of a patient's journey from the ward through the anaesthetic and operating theatre. We saw the checklist completed in all post-operative patients' notes; however, some had not been signed or dated by staff to indicate completion.
- We found that staff completed appropriate risk assessments before and during a patient's stay. These included risk of falls, nutritional assessment and the safer skin prevention bundle. Some of the surgical wards were involved in trialling a new surgical patient care plan. The aim was to have all information including risk assessments within one plan.
- The care records included multidisciplinary team (MDT) input where required. For example, we saw entries made by dieticians, physiotherapists and occupational therapists. Discharge planning was recorded in the notes, beginning on the date of admission.
- We looked at twelve surgical consent forms across the department. All consent forms were signed and dated, and information was legible.
- Information governance was part of the mandatory training. Compliance rates were above the trust target of 90% across all of the surgery services divisions. In the surgical specialities division 94% of staff had completed this training.

Safeguarding

- The trust had a policy in place to safeguard vulnerable adults and children., This was readily available to staff

on the intranet and staff demonstrated easy access of this. The trust's Deprivation of Liberties Safeguards (DoLS) policy and process was also available for staff to access on the trust intranet.

- Staff on the wards had a clear understanding of when a DoLS application was necessary. They were able to demonstrate recent scenarios where an application was deemed appropriate.
- Nursing staff told us there was safeguarding support provided by the trust safeguarding lead and the safeguarding clinical nurse specialist and staff were able to demonstrate how to contact them if needed.
- Safeguarding training was mandatory. Nursing staff were 100% compliant with adult safeguarding training and 99% compliant in safeguarding children level 2. Staff in theatres who worked with paediatric patients were trained up to level 3. However, data provided demonstrated doctors within the surgical services had low adult safeguarding training completion rates. In the gastrointestinal services 43% of doctors had completed this training in surgical specialties 56% of doctors had completed and in the theatres and anaesthesia division 70% had completed.
- Staff in theatres were clear about their role in safeguarding patients. Staff told us the importance of checking the correct consent form had been signed and discussed, ensuring patient understanding of the procedure.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral. We were given examples of concerns they had identified and where referrals were made. Junior nursing staff told us they would seek advice from their mentors or ward sister if required.

Mandatory training

- Matrons we spoke with told us the completion rates for staff within their services were high and were able to access online data to demonstrate completion rates of 100%. Where gaps were noted staff were able to identify reasons why such as sick leave and maternity leave. Ward sisters from a number of wards told us mandatory training rates were 100% as lots of staff were new starters and completed all mandatory training during induction.
- Nursing staff told us their mandatory training was up to date and told us that there were no problems in accessing this training when needed.
- However, mandatory training rates for doctors within the surgical services were below the trust target. For example 65% of surgical specialties doctors had completed the mandatory fire training.

Assessing and responding to patient risk

- Patients' clinical observations were recorded and monitored in line with NICE guidance titled 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) was used to measure patients' vital signs and identify patients whose condition was at risk of deteriorating.
- During the inspection we observed a nurse-led safety huddle taking place mid-morning where doctors, nurses and other members of the multidisciplinary team (MDT) discussed each patient. The nurse looking after the patient would use the NEWS score to highlight patient concerns. Improvements and treatment plans were discussed, such as reducing or increasing oxygen therapy.
- We also observed nurses on the wards carrying out a bedside handover of care at each shift change. Any concerns regarding the patients NEWS or increases in risk were highlighted and escalated appropriately.
- We saw staff on the surgical wards recording patient observations such as heart rate, respirations, blood pressure, temperature and pain. These were recorded in patients' notes on the observations chart. During inspection, we observed health care assistants carrying out this role. A health care assistant we spoke with was able to fully explain the rationale for carrying out the observations. They were knowledgeable about the parameters which would warrant escalation and an immediate review.
- Recent audit data from February 2016 demonstrated that 100% of vital signs and NEWS were recorded on wards T9N, T6, T10S, and on the wards at the WMS site. On T9S 96% of vital signs and NEWS scores were recorded.
- We observed specialist nurses from the critical care outreach team reviewing patients on the ward. Staff

advised us that the critical care outreach team would review all patients discharged from critical care and could also review other patients in ward areas if staff were concerned.

- Nurses used fluid balance charts to assess patients' fluid intake throughout the day. Fluid balance charts were fully completed in patient notes.
- Assessment tools were used for assessing and responding to patients risks. For example: the Malnutrition Universal Screening Tool (MUST), venous thromboembolism tool (VTE) and Safer Skin Care (SSKIN) were all in use. This information was utilised to manage and promote safe patient care.
- We observed evidence in ward areas that demonstrated good risk management in relation to pressure area care. Patients had a safer skin care risk assessment in place. Where a patient scored greater than 10 this demonstrated a risk had been identified and we observed appropriate action was taken. For example, the patient's position was regularly changed and they had appropriate pressure relieving equipment in place.
- We saw surgical patients with anti-embolism stockings in place. During medicine rounds, nurses demonstrated how VTE was assessed by the doctors and VTE prophylaxis was prescribed in all patients' notes we looked at.

Use of the 'five steps to safer surgery' procedure

- All theatre staff across the trust were required to complete a WHO surgical checklist in the operating theatre for each surgical patient. The trust had adapted the NPSA version of the WHO checklist (as recommended in 'safer surgery' implementation guide) to be use for all patients. Theatre teams underwent an extensive full day of training after its launch in 2009 and further on-going training had been provided to new staff.
- During our previous inspection concerns were raised that the safety checklist was not being used fully for all patients. Recent never events within surgical services also raised concerns with clinical commissioning groups that the checklist had not been fully implemented and embedded and during inspection we noticed several on-going improvements were being made.
- The trust joined the NHS England 'sign up to safety campaign in October 2014 which is a national initiative to help NHS organisations improve patient safety. At UCLH one of the work streams within the project was to reduce harm from surgery through the improved use of the 5 steps to safer surgery.
- During inspection we observed good compliance with the surgical safety checklist, with completion of the compulsory elements: 'sign in', 'time out' and 'sign out'. We observed good use of the 'team brief' part of procedure, where the lead staff member was able to discuss risks and issues for each patient. We also saw thorough end of list debriefings with all staff members present and engaged.
- Current observational audits were on-going to ensure compliance with the checklist and furthermore, the quality of leadership, teamwork and engagement throughout the process. There had been extensive staff training on how to auditl behaviours and not just the processes.
- In observational audit results from November 2015, 'team brief's, 'sign in's and 'time out's were carried out for 100% of cases observed. However, distractions and interruptions were observed in 37% of 'time out's and 42% of 'sign out's. Due to this there was a drive to ensure all relevant team members were present and maintained focus throughout each check without being distracted or interrupted.
- Audit results from February 2016 noted some improvements with distractions and interruptions observed in 15% of' time outs' and 25% of' sign outs' which demonstrates an improvement since November. Staff and senior managers told us there were plans to continue these observational audits until "they got it right" and more staff were being trained to carry these out. There was a strong sense of commitment and pride from staff that on-going improvements were a priority.

Nursing staffing

- The trust reports that nurse staffing establishments triangulate from three different sources which included workload measurements such as patient dependency and activity, benchmarking with other organisations and professional consultation.
- Senior ward sisters told us nurse staffing levels were challenging to manage due to a recent reduction in

agency staff use within the trust. Processes had been put in place to actively recruit new staff both to permanent positions and to the staff bank. Oversees recruitment programs had also proved to be successful in some areas of the hospital.

- Senior staff told us how they used the 'safer nursing care tool' to guide ward-staffing establishments. This tool would be used 3-4 times a year to re access acuity levels. Some wards used the tool more often as there had been recent changes to the ward structures.
- There was a staffing escalation policy to be used when a ward area was understaffed. Managers monitored staffing levels regularly to ensure that clinical areas were appropriately staffed. The nurse escalation guide was available to staff to use when there was a shortfall of two or more registered nurses in any one shift. Nurses were encouraged to immediately escalate staffing issues which had triggered a 'red flag' incident. 'Red flag' incidents included unplanned omissions in providing medications, a delay of more than 30 minutes in providing pain relief, vital signs not assessed or recorded as outlined in the care plan and inability to complete intentional rounding.
- Staff shortages were most apparent in the theatre departments. In March 2016, data provided demonstrated a 31% whole time equivalent (WTE) gap of anaesthetic staff, and a 10% WTE gap in scrub practitioners. At WMS there was a 41% WTE gap in anaesthetic practitioners and a 5% WTE gap in scrub practitioners. The recovery staffing for both theatre departments was working at full establishment.
- Data provided demonstrated how active recruitment and the use of internal bank staff had effectively reduced agency staff use within the theatre departments. However, due to the above shortages, agency use in theatres remained significantly higher when compared with other departments within the hospital.
- Senior staff in theatre told us agency staff would work regular shifts and would first work a paid induction shift before working unsupervised. During our inspection we saw examples of two agency staff inductions, which were fully completed.
- Concerns were voiced by nursing staff on T09N and T09S that staff shortages were affecting the care and treatment that patients received. During inspection we observed the nursing ratio to be 1:6 during the day and at night. Staff on the wards raised concerns and gave examples where at night, this ratio could increase to 1:11. Staff advised us that in these situations, incident forms were completed. However, we were told that there was little feedback given in response to these. During our unannounced inspection, we noticed the planned nursing numbers on T09S and T09N were four registered nurses to each ward, but the actual number was three on each ward. This brought the nursing to patient ratio above the recommendation of 1:8.
- One patient on T09 commented that staffing during the day and night seemed extremely low. They observed that medication administration could be delayed because of this and commented that it could take a long time to answer patient call bells.
- Incident data reviewed from September 2015 – December 2015 showed there were seven incidents reported in relation to staff shortages. Two of these incidents related to wards T09N and T09S where staff felt that the staffing levels affected patient care and treatment. The ward manager was able to discuss the reasons for these incidents and demonstrated how feedback to staff had been given. There were no red flag incidents reported during these times.
- The matron on T09 told us that staffing could be a problem when nurses were unexpectedly off work due to sickness. They reported current problems with short-term staff sickness. We were advised that the trust escalation policy would be used in these situations. Where possible the nurse in charge, matron or a nurse specialist would support the ward and that patient safety incidents were monitored closely.
- We were advised that agency use on the wards was kept to an absolute minimum and that the majority of the wards were now agency-free, using only internal bank staff.

Westmorland Street

- During the reconfiguration of surgical services staff were able to decide, through thorough consultation, whether they wanted to transfer with services to WMS within the

specialised thoracic team or move with the cardiac services which were being relocated to a different trust. Similarly staff were able to either transfer to WMS with the urology services or stay at the main UCH site.

- Due to the reconfiguration of services a large number of experienced nursing staff had moved to continue working within cardiac services. We were informed there had been a large drive to actively recruit more nursing staff. Currently there were a large number of new starters, resulting in a junior workforce. The ward was therefore not working at full capacity to ensure junior nurses were given support and time for training and mentoring. Doctors and senior leadership teams were fully supportive of this.
- Agency staff were not used on the wards at WMS as vacant shifts were covered through the hospital's internal bank.

Surgical staffing

- Medical staff skill mix for the surgical directorate across the locations was similar to the England average. The number of consultants was slightly lower at 36% of the workforce, and there were higher levels of registrars at 59% of the workforce, compared with a national average of 37%. Junior doctors (in foundation years one or two) contributed just 2% of the medical workforce, below the England average of 12%.
- There was on-going recruitment at consultant level within the thoracic surgery department, with one WTE vacancy currently at the interview stage and a second which funding had been agreed.
- There had been a recent anaesthetic consultant recruitment drive to ensure consultant presence and reduce theatre lists run by specialist registrars.
- Surgical staff worked on-call rotas to ensure cover was provided 24 hours a day. The GI services implemented a surgeon of the week rota in 2011. The surgeon of the week does not carry out elective work and is available for emergencies only, ensuring that there is an acute surgical ward round every day of the week
- Nurses on the wards told us that there was adequate doctor cover during the week and at weekends and told us they could access doctors quickly when required or if a patient was deteriorating.

Major incident awareness and training

- The trust had a major incident policy in place. A matron we spoke with demonstrated a good understanding of the trust major incident plans and staff in theatre were aware that theatres would stop elective work to ensure availability to accept emergencies.

Are surgery services effective?

Good

We rated the surgery service at UCLH as 'Good' for effective. This was because:

- Patient care and treatment was planned and delivered in line with current evidence-based guidance, best practice standards and legislation. This was monitored on a regular basis to ensure consistency of practice across the services.
- Patients had comprehensive need-based assessments, which included consideration of clinical needs, nutrition and hydration, and their mental and physical health and wellbeing. These assessments guided and identified care and treatment plans. These plans were regularly reviewed.
- The service participated in relevant local and national audits. This included clinical audits and other monitoring activities, such as benchmarking and peer review. Accurate and up-to-date information about audit results and patient outcomes was shared internally and was used to improve care and treatment.
- Continuing professional development was given high priority Staff were proactively supported to acquire new skills and to develop within their roles.
- Consent to treatment was obtained in line with current legislation and guidance. Patients were supported to make decisions. When people lacked capacity to make a decision, 'best interests' meetings were held. The use of restraint was understood as a last resort, and the least restrictive options were always used.

Evidence-based care and treatment

- Staff were able to access national and local guidelines on the trust's intranet and demonstrated how they could access these when needed.

Surgery

- We reviewed a sample of trust policies for surgery. We found appropriate reference to relevant National Institute for Health and Care Excellence (NICE) and Royal College guidelines.
- From review of patient records and discussions with staff, we were satisfied that the service followed NICE guidance on falls prevention, pressure area care, and venous thromboembolism. We also noted catheter care was in line with Royal Collage of Nursing (RCN) guidance.
- The surgical services offered an enhanced recovery pathway for some patients undergoing planned surgery. Enhanced recovery is an evidence-based approach that aims to allow patients to recover from surgery quicker.
- Data provided demonstrated enhanced recovery program availability for colorectal surgeries. There were easy-to-follow guidelines for these patients' care and treatment. Ward staff received support from the enhanced recovery nurse specialist.
- Cardio pulmonary Exercise Testing (CPEx) was used to help estimate risks for patients undergoing surgery.
- We observed nurses checking intravenous cannulas and recording the visual infusion phlebitis score (VIP) in patients notes, in line with RCN guidelines. Staff nurses were able to discuss actions required for each of the scores given.
- There was a comprehensive clinical audit programme for 2015/16 which highlighted the surgery service's involvement in local and national audits. Nursing staff were able to discuss current local audits in their areas: for example, hand hygiene and essence of care audits.

Pain relief

- The hospital used an appropriate pain scoring tool to assess adult pain levels. This contributed to each patient's national early warning score (NEWS). These tools were completed appropriately on observation charts we reviewed. Patients told us their pain was regularly assessed and pain relief was given when needed.
- Pain was managed through a variety of oral medication, epidurals, patches and patient controlled analgesia (PCA). Data provided demonstrated the most common post-operative pain management modality was PCA. Staff were able to demonstrate how to complete documentation to record how much analgesia patients had self-administered.
- In a 2013 survey, 85% of patients commented that everything was done by the hospital staff that could be done to control their pain. This meant that UCLH performed about the same as most other NHS trusts. The trust recognised there was room for improvement and implemented a project to improve pain management of patients.
- There was a consultant-led pain management team available Monday – Saturday, 8am – 5.30pm. Posters advertised contact details of the team. Nurses told us they were accessible and responsive when patients needed to be reviewed. On Sundays anaesthetic doctors were available to assist with pain concerns.
- Patients with an Epidural or PCA had specific care bundles to ensure quality of care. However, an audit completed in February 2016 demonstrated that only three out of the 14 patients with epidurals had the correct documentation completed.

Nutrition and hydration

- The trust used the Malnutrition Universal Screening Tool (MUST) to monitor patients who were at risk of malnutrition. Where patients were identified as at risk of malnutrition, food intake was monitored and recorded. Patients identified as 'at risk' had alerts next to their names on the patient board. This reminded staff to assist and encourage these patients to eat at mealtimes. These patients were also identified through the use of a red tray system.
- Patients identified as at risk of dehydration had fluid balance charts in place to monitor fluid intake and output. There was a red jug initiative in place to identify patients who may need encouragement or assistance to drink.
- Patients told us that there was a large selection of food and drinks available to them. We saw beverage stations on the wards where a range of hot drinks could be prepared.
- At the WMS site hot meals could be provided at different times throughout the day and into the evening for post surgery patients. This flexibility was due to staff being

trained to heat prepared meals in the ward areas. This gave patients a better choice of food options if they had missed a meal time due to procedures or tests outside of the ward.

Patient outcomes

- In urology and colorectal surgery, the trust performed worse than the England average in terms of readmission rates. All other specialties performed better than the England average. We were satisfied that this discrepancy was due to the complex cancer surgeries the trust performed and increased comorbidities within these patient groups.
- Non-elective care had about the same readmission rates compared to the national average.
- The trust benchmarked their performance against national comparisons with other NHS trusts, including the national hip fracture audit, national laparotomy audit and the bowel cancer audit.
- The trust's scores in the 2015 national hip fracture audit were better than. or similar to, the England average for all of the nine measures recorded.
- The trust performed better than the England average in the 2014 bowel cancer audit. The service demonstrated 98% of patients had a CT scan, compared to the England average of 89%. In addition,99% of patients were seen by a clinical nurse specialist compared to the England average of 88%.
- The trust performed better than the England average in the 2014 lung cancer audit. The service demonstrated 100% of patients were seen at an MDT meeting compared to the England average of 96%. Furthermore,94% of patients received a CT scan before a bronchoscopy, compared with the England average of 91%.
- Patient Reported Outcome Measures (PROMs) measure gains in health from patients undergoing hip replacement, knee replacement, varicose vein and groin hernia surgery in England. Performance is based upon responses to questionnaires before and after surgery. Trust performance against PROMs was very similar to the England average in most measures, with the exception of knee replacement. Senior members of staff explained this was due to factors such as higher comorbidity rates in these patients and that this is not considered in the PROMs data collection.
- There was an increase in the number of cancelled operations throughout 2015 due to multiple factors, including post-operative bed availability and patient cancellations. Improvement plans were in place to improve flow through the hospital to free up patient beds. This included encouraging staff to use the discharge lounge facilities when appropriate.

Competent staff

- Senior staff were aware of the implementation date for nursing staff revalidation and were working work to prepare nurses for this. There was a nurse leading on revalidation within the trust who was engaging with staff members nearing their revalidation date. We saw posters advertising information and drop-in sessions on staff noticeboards.
- Newly qualified nursing staff reported a supportive learning environment on surgical wards and in theatres. Staff were allocated a mentor to help with competency and skill development. Nurses told us there were a wide range of opportunities to develop their careers at the trust. Many of the ward sisters and specialist nurses had developed from junior roles within the trust. A newly qualified nurse on the orthopaedic ward told us development and training opportunities were available., For example, he had completed the cannulation training as he had been particularly motivated to get this skill signed off.
- On the thoracic ward at WMS, there were training opportunities available to staff which included accredited specialised courses run by the Royal Marsden, as well as counselling courses to improve skills in managing patients at the end of their life.
- Consultant outcomes were monitored and reviewed through quarterly reports, which were published for each clinician. We saw examples of trauma and orthopaedic reports which collated mortality rates, complications, numbers of readmissions, patient stays of longer than 14 days and the number of cancellations within 24 hours.

- Staff told us they had completed appraisals within the last twelve months and told us this process was useful in identifying learning opportunities.

Multidisciplinary working

- Patient records demonstrated input from a range of allied health professionals, including physiotherapists, dieticians, occupational therapists, clinical nurse specialists and pharmacists. Notes included clear documentation of the staff member and their role.
- We observed good working relationships between different members of the multi disciplinary team (MDT). Wards had introduced staff huddles where nursing staff, doctors and different MDT members would meet to discuss potential patient discharges and treatment plans . We attended one of these meetings and observed the MDT working together to promptly discuss and address any concerns.
- Ward staff told us they were working closer with the staff in the discharge lounge to ensure beds became available as early as possible in the day to improve patient flow through the hospital.

Seven-day services

- There was a 24 hours a day seven days a week emergency operating theatre (theatre 1), as recommended by the National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report. This theatre was available for emergency and trauma cases. On weekday afternoons, a second emergency theatre would be opened from 1pm until 5pm. This theatre also opened on Saturdays. Theatre staff prioritised different patient groups on the operating lists. Priority was given to those with a clinical need, patients who had been previously cancelled and cancer patients.
- There were no paediatric trained recovery nurses available in theatres at weekends or at night for emergency procedures. There was no on-call provision. Staff told us paediatric patients would be scheduled for the following morning whenever possible. In emergencies, adult trained nurses would recover a paediatric patient.
- Orthopaedic physiotherapists provided care seven days a week to post-operative orthopaedic patients. There was an on-call respiratory physiotherapist available at weekends and physiotherapy and occupation therapy overnight on-call cover.
- There was an integrated discharge team who worked 8am-5pm on weekdays and 9am-5pm on weekends and bank holidays to assist ward nurses in planning and implementing patient care ready for discharge.
- There were consultant-led ward rounds Monday through to Saturday. Consultants were on-call on Sundays.

Access to information

- Handovers took place at 7.45 am and at7.45 pm each day. Nursing staff discussed any general ward issues concerns or changes, such as incident learning. A more detailed handover would then take place at the patient bedside between the nurses caring for those patients.
- Nurses told us that policies were available on the trust intranet and demonstrated how to access these. Computers were available at the end of each bay. There were adequate computers on trollies for ward rounds and medicine rounds.
- Ward information such as patient feedback, safety information and staffing numbers were provided at the entrance to each ward and were updated daily.
- There was a range of information available to patients about different aspects of their care. For example, pressure area care and infection prevention advice. However, this information was only available in English and not in other languages.
- On the wards and in theatres we saw information boards which displayed varied information for staff. These included infection prevention and control, discharge planning, Duty of Candour and peripheral line maintenance.
- Staff told us about the “message of the week”, a trust wide communication tool where a different topic was shared with staff each week. We saw these pinned on staff noticeboards and heard them discussed at handovers.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff on the thoracic ward at the WMS site demonstrated good knowledge and understanding of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Nurses told us that the MCA was part of their induction training and then needed to be updated yearly.

Surgery

- We saw three examples of consent forms for patients who lacked capacity to consent for themselves. All three had fully documented and appropriate discussions with family and next of kin.
- During the unannounced inspection we visited T10S, where a health care assistant (HCA) was providing support to patients living with dementia who required specialist care.. The HCA ensured patient safety through the use of bed rails to prevent patients falling. However, patients were not restricted and were supported to safely mobilise when required. If movement did need to be restricted due to safety concerns staff were aware this needed to be in the patients best interests required a proportionate response and would be escalated to the nurse in charge.

Are surgery services caring?

Good

We rated the surgery service at UCLH as 'Good' for caring. This was because.

- Feedback from patients and their relatives was overwhelmingly positive about the treatment they received from staff. Patients reported the care they had received exceeded their expectations and that they would recommend the service to others.
- We observed staff treating patients with dignity, respect and kindness during all interactions.
- Patient's emotional and social needs were considered by staff and were embedded within their care and treatment pathways.

Compassionate care

- The majority of patients we spoke with were positive about the care they received. Patients told us staff were "excellent" and "highly professional".
- Patients told us they were always treated with compassion. One patient reported she had complete confidence in the care she had received. All levels of staff, from the cleaners to the consultants, treated her in a caring way.
- On T09, three patients informed us that it took a long time for nurses to answer the call bells at night. During the evening we observed relatives providing basic care to patients, such as helping them to the toilet, as staff were already busy.
- Senior nurses and matrons were proud of the quality of the care delivered by their staff on the surgical wards. Displays of 'thank you' cards from patients were seen around the nurses' stations on wards. Positive comments from patients were displayed at the entrances to the wards.
- The areas we visited were compliant with the same-sex accommodation guidelines. We found patients' dignity was respected and the curtains were closed around the patient when they were being examined or provided with personal care.
- The NHS friends and family test is a survey that measures patients' satisfaction with the healthcare they have received and asks whether they would recommend the service to friends and family who needed similar treatment. Results between January 2015 and November 2015 for the surgical wards were consistently above the England average.

Understanding and involvement of patients and those close to them

- Staff respected patients' rights to make choices and endeavoured to communicate with patients in a way they could understand. Patients felt involved in their care and reported they had opportunities to ask questions.
- One patient had been unhappy with the side effects of a particular medication. She had the opportunity to discuss suitable alternatives and have the medication changed.
- One patient and their family told us they had been fully briefed about their surgical pathway, from admission through to discharge, so they knew what to expect. Wards provided patients with information on common procedures and what to expect throughout their surgery.
- Another patient told us how they could contribute and add comments during the bedside handover and ward rounds. They told us that they could add anything they felt had been missed, or wanted to highlight about their care and treatment.

- Flexible visiting times on the wards meant families had the opportunity to visit their relatives at times which were convenient.

Emotional support

- Clinical nurse specialists provided emotional support to patients throughout their surgical pathways. Patients complimented the support they were given and liked that they had a consistent point of contact throughout their care
- The surgical wards did not have specific assessments available to assess for anxiety or depression in their patients. Nurses told us that assessing patient care was part of their daily assessment and they would document an concerns in the notes.
- Senior staff on the long stay urology ward at WMS were aware of the pressures junior nurses experienced when caring for patients at the end of life. Due to this staff were provided with extra training and external courses were provided facilitated at the Royal Marsden Hospital to assist with staff caring for palliative patients.

Are surgery services responsive?

Good

We rated the surgery service at UCLH as 'Good' for responsive. This was because.

- There was a proactive approach to understanding the needs of different groups of people, including those who were vulnerable or who had complex needs. Staff demonstrated how they delivered care in a way that met these needs.
- Patients were encouraged to raise concerns or complaints and we saw evidence that these were responded to in a respectful and timely manner.

However

- Patient flow through theatres still required some improvement. Theatre utilisation data demonstrated they were not meeting the trust target of 85%. Patients often stayed overnight in the recovery department when no beds were available.

Service planning and delivery to meet the needs of local people

- The trust worked collaboratively as part of the national cancer vanguard with other hospitals, primary care organisations, commissioners, public health bodies and charities across north central and north east London. This aimed to deliver better outcomes and experience for patients with cancer.
- The trust was actively working with commissioners to provide an appropriate level of service based on demand, complexity and commissioning requirements. This had included the reconfiguration of surgical services to specialise in areas where they could provide the best patient care such as thoracic and urology services.
- The prostate one-day service had been developed to reduce the number of hospital visits patients needed by providing a comprehensive service within the same appointment.
- Services were planned to enable patients to have pre assessment and post operative care provided to them closer to home within their local hospitals.

Access and flow

- The trust performed worse than the England average for referral to treatment (RTT) times across surgical specialties from October 2014-May 2015. Since May 2015, UCH has performed better than the England average for the percentage of patients being referred for treatment within 18 weeks. Current performance data demonstrates that all services are now compliant in treating 92% of patients within 18 weeks of referral.
- Senior nurses and service managers told us that improving patient flow though the hospital was a high priority. There had been on-going work to ensure safe, timely and effective patient discharges. Staff demonstrated they accomplished this through escalating delays to the ward sister, utilising the discharge lounge and planning discharges in advance.
- There was a dedicated discharge team available seven days a week, who were able to assist with discharge pathways when there were delays.
- According to data supplied by the trust, the median theatre utilisation at UCLH was 73%. Over a three month period, it ranged from 50%-83%. The utilisation target set by the trust was 85%. There was on-going work to

improve theatre utilisation. Managers were taking a hospital wide approach, looking at patient flow from admission through to discharge, and how this impacted on the theatre department. It had been recognised that delayed discharges on the wards could impact theatre utilisation times.

- One example of a trust wide approach was the introduction of the "home for lunch" scheme. This involved daily multidisciplinary team meetings, to discuss patient discharges and resolve any potential delays which would prevent them from being discharged in the morning.
- Theatre sessions were reviewed six weeks in advance to ensure any sessions not used could be offered to other specialities.
- The theatre coordinator worked in conjunction with the duty consultant anaesthetist to plan and manage the clinical activity across the theatre complex on a day-to-day basis.
- The previous CQC inspection noted concerns in patient flow through the theatre department. Although there had been some improvements, some concerns remained. Theatre staff described difficulties in keeping their theatre lists running due to the lack of space in recovery. This often affected theatre utilisation and patient flow and was due to patient beds not being available in ward areas.
- There were often patients who remained in the recovery area overnight as beds were not available elsewhere in the hospital. Staffing in the recovery area had been increased to ensure safety of these overnight patients. During inspection, there were three patients in recovery who did not have allocated beds on the wards and there were five patients in recovery who had been ready for discharge to the wards for more than three hours. This was due to late discharges of the previous patient and bed areas not being cleaned.
- There was a separate entrance and waiting area for paediatric patients. The waiting area had age appropriate toys and books. If required, a play specialist was available for distraction. Paediatric patients were recovered in a separate recovery area which had been made child-friendly with bright paintings on the walls. There was also a dedicated children's theatre with a child friendly anaesthetic room.

Meeting people's individual needs

- The surgery service proactively considered and responded to specific individual needs, including patients with complex needs and cultural and religious requirements.
- There was a Christian chapel, a Muslim prayer-room, a quiet room and a Jewish Sabbath room within the chaplaincy area. They were open 24/7 for patients and their relatives.
- Due to the needs of the local population, the trust provided a homeless care team in the discharge lounge. The team was made up of hospital staff and staff from other agencies to help with the safe discharge of homeless patients.
- Staff demonstrated a clear understanding of the needs of patients living with dementia. The purple 'forget me not' scheme was in use to identify patients living with dementia. On ward T10 there was an activities trolley which was used to engage patients living with dementia. On some of the wards patients living with dementia were kept within in a cohort bay. Staffing acuity was increased for this bay to ensure patient safety.
- Policy stated that an assessment of mental state should be carried out on all patients over the age of 65. We saw evidence that these assessments had been completed. We also saw evidence of patients being assessed for the presence of delirium.
- Nursing and nursing assistant staff told us they had received e-learning training in dementia awareness.
- The trust used hospital passports to identify the needs of patients with learning disabilities. Patients with learning difficulties were be treated in a side room whenever possible. There was a trust wide clinical nurse specialist available Monday – Friday.
- The trust interpreting service was provided via Language Line Solutions (LLS). Access to both telephone and face-to-face interpreting and translation was available 24/7.Staff were familiar with the process of booking an interpreter when required. Staff also told us that there were lots of staff who spoke different languages who would be used to translate for patients if available.
- There was a service available to provide web based sign language interpreting services via video link, should an

interpreter be required for a deaf patient. Some staff were unfamiliar with this service. However, they stated they would talk to the senior nurse in charge if they had concerns about a patient whom they could not communicate with.

- We noted that there was limited available space for staff to talk with relatives. Staff told us that this was a concern when dealing with sensitive issues and they would sometimes have to use office space for this.
- Welcome packs were available for all patients. These packs included non-slip socks, ear plugs, an eye mask and a welcome booklet. The booklet gave patients information on values, visiting times, food and drink availability, managing pain, avoiding infection, contact information, information on how to complain and details about preparing to go home.

Learning from complaints and concerns

- Between April and December 2015 the trust received 573 complaints, of which 184 (32%) were related to the surgery and cancer board. Of these 53% related to surgical specialties, 19% related to the cancer division, 26% related to GI division and 2% related to theatres and anaesthesia division.
- Senior staff told us there were no particular themes within complaints and most complaints were about isolated and individual concerns.
- Towards the end of 2015 it was noted that there was a sharp increase in the number of complaints received for the surgical specialties division. A significant number of complaints related to the transfer of ophthalmology services to another hospital and concerned communication about this move.
- Service leaders told us matrons would telephone patients who had submitted complaints and would set up face-to-face meetings to discuss their concerns whenever possible.
- Posters and leaflets explaining how to make a complaint were widely available throughout the department.
- There was evidence of learning from complaints. Each ward had a 'quality and safety outcome' board where reported complaints and concerns were displayed and actions taken could be communicated. For example, on T06 there had been a concern that call bells were not responded to in a timely manner. The corresponding action stated staff should remain by patients' bays when not providing care.

Are surgery services well-led?

Outstanding ☆

We rated the surgery service at UCLH as 'Outstanding' for well-led. This was because:

- There had been recent reconfigurations of surgical services at the UCH main site and at UCH at WMS. Staff at all levels demonstrated they were proactively engaged and involved in the changes. Management teams ensured that the voices of all staff were heard and acted on during this time. Comprehensive and successful leadership strategies were demonstrated to be in place during this time.
- The leadership of the service actively promoted staff empowerment to drive change and improvement. Staff are encouraged to take ownership of their roles at all levels to ensure any concerns could be voiced.
- There was a strong focus on continuous learning, development and improvement for all levels of staff.
- Clinical and operational information was collected and analysed. This was used proactively to identify where improvements were needed.
- There were comprehensive governance and risk management processes in place, which functioned effectively from board level downwards. Junior staff members demonstrated a clear understanding of these.
- There was a clear 2015-2020 cancer strategy in place based on outcomes, research, experience and workforce. UCLH is part of the national cancer vanguard working with other organisations to improve cancer pathways for patients.

However

- Although there was a clear cancer strategy in place there was no clear strategy for the other surgical services. There was a lack of staff knowledge in terms of vision for these other services.

Surgery

Vision and strategy for this service

- The Trust described their vision to deliver top quality patient care, excellent education and world-class research. The surgery services at UCLH balances the provision of specialist services with delivering acute services to local populations.
- Staff across the surgical services demonstrated they were aware of the trust values of 'safety', 'kindness', 'teamwork' and 'improving' and were able to demonstrate how these values contributed to their work.
- We were advised that around 80% of the surgical workload at UCLH was cancer related. Cancer and surgery sit within the same board, managed by one medical director. Therefore, there was a strong focus on the cancer services when discussing the vision and strategy for the surgical services. There was a clear 2015-2020 cancer strategy in place based on outcomes, research, experience and workforce.
- Staff across the surgical services including doctors, nurses and care staff were able to give examples of how they were improving care for cancer patients in line with this strategy. This included improving patient pathways, staff training and development and emotional support for patients on the ward.
- UCLH is part of the national cancer vanguard working with two other organisations to improve cancer pathways across London.
- As part of the national cancer vanguard UCLH plan to lead and work with other hospitals, primary care, commissioners, public health and charities across north central and north east London to improve cancer outcomes, advance cancer research and improve cancer patients' experience.
- Due to the London cancer and the London cardiac reconfigurations, there had been large scale changes to services within the surgical specialities division within the previous 12 months. In August 2014 it had been agreed that urology, thoracic surgery and respiratory Medicine (making an integrated thoracic unit) would move to WMS. However, it became apparent that the trust was unable to move respiratory medicine from the main UCLH site due to safety concerns and increased running costs.
- Staff told us that they felt unsettled during this time. During this time staff described a destabilised work force for a short time. Since then, there had been large nursing and doctor recruitment drives to improve staffing levels and morale within the workforce and staff said they felt more engaged within the future vision and plan.
- There were on-going improvement strategies in place throughout the separate divisions and it was clear that there was a drive for continuous improvement. In theatres, we were told that the team were working towards all theatre staff being multi trained so they could rotate between the scrub, anaesthetic and recovery areas of the department. Currently four members of staff had completed this training and there were plans to set up their own theatre school in collaboration with Kings University to develop and train their own staff.

Governance, risk management and quality measurement

- Clinical governance structures were in place across the surgery and cancer board and staff we spoke with felt they were effective. We spoke with ward managers across the surgical wards and in theatres and staff were able to demonstrate good awareness of the governance arrangements.
- Staff were able to describe in detail the actions taken to monitor patient safety and risk. This included incident reporting, keeping risk registers up-to-date, completing regular audits, sharing learning and feeding back to other staff.
- The surgery and cancer board met once a fortnight to share the chief executive's team brief and discuss how the surgery and cancer board were delivering the trust objectives. They also presented current performance indicators and shared leaning from serious incidents.
- There were divisional governance meetings once a month for theatres and anaesthesia, surgical specialties, gastrointestinal services and cancers divisions. These meetings followed a similar format and included updates from the surgery and cancer board, financial consideration, risk register updates, details of complaints and incidents and departmental updates.
- Each directorate within the surgical specialities division had monthly meetings. We reviewed minutes from the

head and neck, and trauma and orthopaedic, monthly meetings which followed a similar meeting structure and discussed on-going issues, complications, adverse incidents and complaints.

- At WMS there was a separate governance meeting once a month. There were also separate governance meetings for both Urology and Thoracic services. There were regular WMS street forums where patient and staff experiences, incident risks, complaints and health and safety were discussed.
- We reviewed the risk register and found that it was updated frequently and reflected current risks to the service. We noted that risks were reviewed regularly with regular action points noted to mitigate risks.
- In theatres, staff told us there were quarterly governance and training days held for all staff. On these days all elective theatre work stopped to ensure as many staff as possible could attend.

Leadership of service

- The surgery and cancer board was made up of five separate divisions, cancer, gastrointestinal services, surgical specialities, imaging and theatres and anaesthesia. Each division was led by a divisional manager and a clinical director.
- Staff told us senior management teams were visible and took part in regular walk arounds in their departments to meet staff and get to know the areas.
- Senior management teams told us matrons and ward sisters had provided strong and clear leadership to their teams throughout large scale changes across the divisions.. When we spoke with the matrons they demonstrated a clear understanding of their service performance. They were able to openly discuss where there were challenges and identify where improvements were needed and how to address these.
- Matrons and ward sisters were visible and supportive towards staff. Senior sisters complemented the support available to them from their matrons and senior managers.
- Senior nurses undertook relevant leadership and management training. There was a two year matron development training program, as well as access to connect health leadership program for band 7 nurses. There was also a band 5-6 development program which had started in the head and neck directorate and was now being rolled out trust wide. Nurses we spoke with told us they had good development opportunities with access to both internal and external training. In theatres there were plans to provide their own accredited theatre course with academic links to Kings College.
- In theatres there was a bespoke band 3 training and development in progress for new starters. Each new staff member would be allocated a buddy and a home theatre and would complete internal rotations into different areas of the theatre department.

Culture within the service

- During inspection of the surgical services it was evident that there had been large amounts of change. Despite this staff said they enjoyed working in their teams and commented that staff worked well together and had supported each other throughout these changes. There were high levels of staff satisfaction throughout the surgical departments and it was clear that staff were proud of the organisation as a whole and their individual work areas.
- There were many established members of staff within the surgical services who had developed their careers within the trust. We met with several staff across different areas of the surgical services who had been junior nurses and had developed to senior sister and matron levels. Senior staff told us they worked hard to develop their own staff and explained staff development and retention was a high priority. However, some staff felt that black and ethnic minority staff were not successful in applying for promotional opportunities, despite applying several times and having improved in areas which had been suggested from previous unsuccessful applications.
- Junior nursing staff we spoke with told us there were opportunities to progress within their career, either through management and leadership programs or opportunities to improve their clinical skills.
- Health care assistant staff told us there were opportunities to progress from band 2 to band 3 and there were opportunities to work in different areas of the trust if they requested.
- The WMS theatre team had recently won the “celebrating excellence award for teamwork". This was

due to the successful opening of seven theatres and two recovery areas while maintaining excellent patient care and demonstrating a positive approach towards organisational change.

- Staff in theatres described how they had worked towards a shift in the working culture in the department as prior to this there had been some concerns around bullying and staff hierarchy. This had prevented staff speaking up to improve patient care. Name boards had been introduced so theatre teams knew the names of all the staff in the team. Staff had training about taking pride and ownership of their role within the theatre pathway. Due to these improvements, junior staff had more involvement in the safety checklist and ensuring patient safety and staff at all levels told us they were actively encouraged to raise concerns.

Staff and public engagement

- During inspection, we heard how staff were involved in improvements in their departments. In theatres the nurses had recently completed an audit and improvement program to improve patient warming through the theatre pathway. Staff had re-audited since implementing patient warming in the anaesthetic room and noticed improved patient outcomes in temperature control.
- Senior members of the anaesthetic team had introduced the use of optiflow to improve pre oxygenation prior to induction of anaesthesia. Staff told us they were involved in the ongoing development of the trust policy for the use of this equipment.
- In addition to the Friends and Family Test, individual surgical departments conducted patient experience surveys to measure patient satisfaction against indicators such as waiting times, procedure explanation and being kept informed. These results were displayed at the entrance to each department.
- Patient feedback was displayed at ward entrances as 'You said – we did'. For example, on one ward a patient had raised concerns about the noise at night, and staff had replied that they will keep conversations to a minimum away from patient areas.
- We saw staff noticeboards available throughout the surgical departments providing staff with information about departmental and trust wide changes, including available training and developmental opportunities.
- There was a monthly staff newsletter called "Inside Story" circulated to all staff in the trust. The newsletter celebrated improvements in care, published staff survey results including actions and shared patient stories.

Innovation, improvement and sustainability

- The one-stop urology clinic was introduced as a trial and expanded and rolled out to all two week wait GP referrals in Oct 2015. Prior to this, patients were visiting the hospital four or five times on average prior to receiving prostate cancer diagnosis. The one-stop clinic managed to combine consultation, MRI scans, results of MRI scans and offer of trans-perineal image guided biopsy (where appropriate) on a single day. This was part of the innovation that won the HSJ innovation award.

Critical care

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

Information about the service

The critical care unit (CCU) consisted of general adult intensive care, high dependency care, post-anaesthetic care unit (PACU), critical care outreach and critical care follow-up clinic. There were 35 beds on the third floor of the University College Hospital Tower (T03). A new service provision was opened at Westmoreland Street in June 2015 providing further nine beds. The same multidisciplinary team managed and staffed both units. We inspected both sites.

The critical care outreach team includes the resuscitation team, and is called the Patient Emergency Response and Resuscitation Team (PERRT). The PERRT team assisted in the management of critically ill patients across the hospital.

The unit can be flexibly staffed and configured to provide care and treatment for level three intensive care patients and level two high dependency patients and operates as one single critical care unit.

Patients were admitted to the CCU following elective and emergency surgery, but a proportion were admitted from the hospital ward, when they became unwell. Patients were also admitted from the emergency department.

Patients who had been admitted in the CCU for more than three days were offered appointments to the follow-up clinic.

We visited the critical care units in the tower (T03) at the main hospital site and at Westmoreland Street over the course of three announced inspection days. During our inspection, we spoke with 35 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the directorate leadership team, nine patients and eight relatives. We checked 11 patient records, four medication administration records (MAR) and many pieces of equipment.

Critical care

Summary of findings

Overall we rated the critical care unit at University College Hospital as 'Good' because:

- There were systems in place to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us about improvements in practice that had occurred as a result.
- Bed spaces on both units complied with the Department of Health's Health Building note HBN 00-09, which sets out a minimum standard of space for effective infection control.
- Safe numbers of staff cared for patients using evidence-based interventions. There was good access to seven-day services and the unit had input from a multidisciplinary team.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- Staff were caring. They obtained consent prior to procedures and maintained patient privacy and dignity.
- The majority of patients were admitted within four hours of the decision to admit and data showed there had been no patients transferred for non-clinical reasons. The unit also had fewer readmissions within 48 hours of discharge.
- Staff had access to communication aids and translators when needed, giving patient the opportunity to make decision about their care, and day to day tasks. There were very few complaints about the services and staff dealt with complaints appropriately.
- There was good local leadership on the unit and staff reflected this in their conversation with us. Staff and patients were engaged in decision making on the unit and provided feedback about the service.
- The unit was engaged in research a large team of nurses and doctors dedicated to the research programme.

However:

- Compliance with infection prevention and control guidelines was not consistent for other visiting staff reviewing patients on the unit.
- There was no flagging system for patients living with dementia or with learning disabilities so it was unclear how staff identified these patients and adapted their care accordingly.
- The number of out of hours discharges were higher when compared to similar units and acute mortality rates were also slightly worse than other similar units.

We rated safe in critical care as good because:

- There were systems in place to protect patients from harm and a good incident reporting culture. Learning from incident investigations was disseminated to staff in a timely fashion and they were able to tell us about improvements in practice that had occurred as a result.
- The environment and equipment was clean and supported safe care. It was fit for purpose critical care staff complied with infection prevention and control guidelines.
- Staff had access to a wide range of equipment and all equipment was adequately maintained.
- Staffing on the unit was in line with national guidelines, although bank nurses and locums were often used to achieve this. Staff had achieved the trust target for most of the mandatory training modules.
- Patient records were comprehensive, with all appropriate risk assessments completed.
- The Patient Emergency Response and Resuscitation Team (PERRT) reviewed all deteriorating patients and the team worked closely with critical care to facilitate admission to the unit.

Critical care

- Medicines were generally stored safely and securely although we observed maximum and minimum drug fridge temperatures were not recorded.

We rated effective in critical care as good because:

- An experienced team of consultants and nurses delivered care and treatment based on a range of best practice guidance. Patients were cared for by appropriately qualified nursing staff who had received an induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.
- There was good access to seven-day services and the unit had input from a multidisciplinary team. Staff managed pain relief effectively and patients' nutrition and hydration needs were closely monitored.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- The unit had fewer readmissions within 48 hours of discharge and rarely transferred patients for non-clinical reasons.

We rated caring in critical care as good because:

- The critical care unit provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.
- Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
- Staff provided emotional support to patients and patients were able to access the hospital multi-faith chaplaincy services, when required. Additional support from a clinical psychologist was available to patients.
- Patients' feedback was sought and the latest yearly friend and family test results showed 95% of patients would recommend the CCU.

We rated responsive in critical care as good because:

- The senior staff had an understanding of the needs of the service and patients and worked well with other specialities to facilitate access to the CCU.
- The majority of patients were admitted within four hours of the decision to admit and data showed there had been no patients transferred for non-clinical reasons.
- Staff had access to communication aids and translators when needed, giving patient the opportunity to make decision about their care, and day to day tasks.
- Quiet rooms were available for staff to speak to relatives and relatives had access to a relatives' room.
- There were very few complaints about the services and staff dealt with complaint appropriately.
- Delayed discharges were better when compared with similar units and did not currently impact on admissions to the unit.

We rated well-led in critical care as good because:

- The leadership team had a clear vision and strategy and staff were able to verbalise future plans. There was a robust governance structure, both within critical care and within the directorate.
- We saw good local leadership within the unit and staff reflected this in their conversations with us. Staff said the culture on the unit was very open and any member of staff could approach the leadership team with any issues or new ideas.
- There was evidence of staff engagement and changes being made as a result
- Patients were engaged through surveys, feedback forms and a quarterly patient forum.
- The unit was engaged in research and there was a large team of nurses and doctors dedicated to the research programme.
- The management team had oversight of the risks within the services and mitigating plans were in place.

Critical care

Are critical care services safe?

Good

We rated 'safe' as 'good' because:

- There were systems in place to protect patients from harm and a good incident reporting culture. Learnings from incident investigations was disseminated to staff in a timely fashion and they were able to tell us about improvements in practice that had occurred as a result.
- The environment and equipment was clean and supported safe care. It was fit for purpose critical care staff complied with infection prevention and control guidelines.
- Staff had access to a wide range of equipment and all equipment was adequately maintained.
- Staffing on the unit was in line with national guidelines, although bank nurses and locums were often used to achieve this. Staff had achieved the trust target for most of the mandatory training modules.
- Patient records were comprehensive, with all appropriate risk assessments completed.
- The Patient Emergency Response and Resuscitation Team (PERRT) reviewed all deteriorating patients and the team worked closely with critical care to facilitate admission to the unit.
- Medicines were generally stored safely and securely although we observed maximum and minimum drug fridge temperatures were not recorded.

However:

- Compliance with infection prevention and control guidelines was not consistent for other visiting staff reviewing patients on the unit.
- There was limited storage space on the unit and we found equipment kept on one of the corridors at T03.

Incidents

- The critical care unit (CCU) reported no "never events" in the previous twelve months. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- There were two serious incidents reported in the unit between January 2015 and December 2015. These incidents occurred on the third floor at UCLH (T03).
- We looked at the investigation of a serious incident from March 2015. This was in relation to a grade 3 pressure ulcer. We saw that the incident was fully investigated using the serious incident framework and an action plan was developed as a result. The investigation team recommended staff education around the use of dressings; barrier products and accuracy of pressure ulcer grading; and management of moisture related skin damage. Nursing staff completed the training sessions in October 2015.
- We also looked at the investigation of the second serious incident from October 2015. This was in relation to a dislodged tracheostomy. This was also fully investigated using the serious incident framework. The investigation team recommended formal airway risk assessments should be made on regular basis for critical care patients; formal pathway for surgical tracheostomy; difficult and altered airway training for staff; and a prompt in CCU documentation for formal airway risk assessment. Airway and turning plans were in place during our inspection and staff completed formal airway risk assessments for patients. Each patient had a board with information about their airway and turning plan. In addition, staff carried out complex turns with medical supervision.
- Staff reported incidents on an electronic system and all the staff we spoke with during the inspection knew how to report an incident. They told us they received feedback on individual incidents they reported and on incidents that affected their unit. Senior staff shared information regarding incidents and learnings at safety huddles, during handovers, and in bulletins. This was also displayed on the staff notice board within the unit.
- There were 513 incidents reported between January 2015 and December 2015. 464 incidents occurred at T03 whilst 49 incidents occurred on the critical care unit at Westmoreland Street. The three main categories for the incidents reported were pressure damage/moisture

lesion, patient accident/injuries and medication. Senior staff told us that they have a high incident reporting rate because staff were encourage and empowered to report incidents. 97% of the incidents were reported as causing "low harm" or "no harm" to patients. Seven of the incidents were reported as causing "moderate harm" while two incidents were reported as "severe incidents". Three incidents were reported as having caused or contributed to death.

- The critical care team held monthly mortality and morbidity (M&M) meetings to discuss mortality on the CCU. Minutes of the recent M&M meetings indicated that areas of learning were identified and actions from the meetings were specified. In November 2015, the meeting discussed an incident when a nasogastric tube (NGT) was displaced as a patient was being turned. The action plan from the meeting included an audit of the occurrence of inadvertent NGT removal and review of techniques and equipment to prevent removal. This is now on the list of the ongoing audits in the unit.
- Staff understood their responsibility under the duty of candour regulations and followed the correct process. Information about the duty of candour process was displayed prominently on the staff communication board. A separate "sign up to safety" leaflet was displayed on the board. This covered several topics including "reducing avoidable harm", "learning from incidents", "implementing the duty of candour", "sharing learning and approaches" and "supporting staff".

Safety thermometer

- The critical care unit participated in the NHS Safety Thermometer Survey used to collect local data on specific measures related to patient harm and "harm free" care. Staff collected data on a single day each month to provide a snap shot of performance in key safety areas. These included pressure ulcers, falls, catheter associated urinary tract infection (UTI) and venous thromboembolism (VTE).
- All patients had their level of risk assessed for venous thromboembolism (VTE), falls and nutrition, and staff reviewed this at regular intervals. The trust's priority trend for the unit showed 100% assessment rate for VTE between March 2015 and January 2016.
- The unit displayed clear, easy-to-read information for staff, patients and visitors on the two sites at T03 and Westmoreland Street. The information at T03 recorded 210 days since the last fall of a patient, which took place in August 2015: 21 days since the last pressure ulcer, which occurred in February 2016 and 33 days since the last case of clostridium difficile (C.Diff). The information at Westmoreland Street showed no falls since it opened (in June 2015), no pressure ulcers and no MRSA.
- Each bay in T03 had a patient activity and safety huddle board with clear information about the nurse looking after each patient, patient acuity, nutrition, turning and pressure ulcer risk. Pressure ulcer risk was colour coded: with red indicating high risk, amber advising close monitoring and purple for patients with an existing pressure ulcer. There were personalised airway and turning plans by each patient's bedside in both units.
- The CCU on both sites did not display information about the expected and actual staff levels for the day. Senior staff explained that it was difficult to keep it up to date due to the volume of discharges and admissions they had. However, both sites displayed information about the nurse looking after each patient and patient acuity.
- The unit provided harm free care for six of these months between February 2015 and January 2016 and the type of harm reported in the other months were mainly pressure ulcers and one fall.

Cleanliness, infection control and hygiene

- The critical care unit on both sites looked clean, well maintained and hygienic. All the patients we spoke with were satisfied with the cleanliness. Other areas within the critical care units, such as the relatives waiting area, quiet room, toilets, the sluice room and nursing stations, were clean and tidy.
- There were dedicated staff for cleaning the critical care unit. Cleaning schedules were displayed in the critical care unit at T03 in accordance with the Department of Health guidelines. Cleaning staff understood cleaning frequency and standards and said they were part of the ward team. A different team carried out additional deep clean of the side rooms once an infectious patient was discharged. Cleaning staff said they received all the appropriate training required for the role and were supported by the domestic supervisor and nurses. The domestic supervisor carried out weekly cleaning audits and senior staff provided feedback to the cleaning staff.

- However, a cleaning schedule was not displayed in the critical care unit at Westmoreland Street. One of the cleaning staff we spoke to was not aware of the cleaning schedule. She explained that she cleans the unit regularly and cleans each bedside after every discharge.A sign in the unit specifies the level of cleaning required following discharge of a patient.
- Equipment used on the units, including commodes and bedpans were clean. Staff used "I am clean" labels to indicate that an item of equipment was cleaned and decontaminated. Bed space curtains were labelled with the date they were last changed. However, we observed two sharps bins with bloodstains at T03. They were left open instead of being "soft closed".
- Hand sanitizers were readily available at the entrances to the critical care unit and at each bedside. We observed staff and visitors decontaminating their hands when entering and leaving the unit. Staff had easy access to personal protective equipment (PPE) in all areas we inspected and used PPE as required. However, we witnessed visiting medical teams approaching patients without aprons and CCU staff did not challenge them.
- The information displayed on T03 showed that hand hygiene compliance was 92% during the period of our inspection and the last recorded MRSA incident occurred in February 2015. The critical care unit also audited compliance with a new "infection control improvement measure". This was a more rigorous tool aimed at improving compliance with infection control measures in the unit. It looked at the facilities and audited adherence to infection control precautions including whether staff were "bare below the elbow", use of PPE and clean sinks.Compliance with the "new infection control improvement measure" was 85%. Hand hygiene compliance at T03 was 88% in June, 95% in July, 92% in August, 95% in September, 94% in October and 85% in December. The trust's target for hand hygiene compliance was 90%.
- The information displayed on Westmoreland Street showed that hand hygiene compliance was 95% during the period of our inspection and there was no MRSA incident since the unit opened in June 2015. Compliance with the new infection control improvement measure was 85%.Hand hygiene compliance at Westmoreland Street was 94% in September, 93% in October and 82% in November.
- A dedicated infection control nurse worked on the critical care unit twice a week. Staff carried out a root cause analysis investigation for all infections on the units. Staff identified areas for improvements where audits indicated lower rates of compliance such as more thorough cleaning instructions that included specific areas and equipment.
- The trust priority trend for the CCU reported one incident of unit acquired methicillin-resistant staphylococcus aureus (MRSA) between February 2015 and January 2016. There were nine clostridium difficile cases and three methicillin-susceptible staphylococcus aureus (MSSA) cases in the same period.

Environment and equipment

- The critical care unit at T03 had 11 side rooms and Westmoreland Street had one side room. Only one of the side rooms at T03 had a negative pressure control for airborne infections and a decontamination lobby in line with best practice recommendation.
- Bed spaces on both units complied with the Department of Health's Health Building note HBN 00-09, which sets out a minimum standard of space for effective infection control.
- Staff maintained a reliable and documented programme of checks including portable appliance testing (PAT). Nursing staff on the units had maintained resuscitation equipment with daily documented checks.
- We observed resuscitation equipment was readily available on the units. Difficult airway and emergency tracheostomy equipment was available on the unit.
- Staff reported good access to technical support when there were problems with equipment. There was a dedicated Medical Equipment Management Service (MEMS) team based in the critical care unit. The team offered 24 hours on call service, seven days a week. The team offered routine maintenance of equipment and carried out repairs when necessary. All the equipment we inspected had maintenance stickers showing they had been serviced in the last year.

Critical care

- Each bay in the critical care unit had a ceiling hoist and staff could move it over each bed space to facilitate rehabilitation.
- There was a limited storage space on the unit and we found equipment kept on one of the corridors at T03. The equipment partly blocked the corridor and we were concerned that staff would not be able to move a patient through the corridor in an emergency. Staff removed it after we highlighted it to senior members of staff.

Medicines

- Medicines were stored in a secure room. Controlled drugs (CDs) were stored in a locked cupboard and the nurse in charge held the keys. Staff documented handover of CD bay keys and two nurses checked the CD cupboard every twelve hours in line with the trust's policy.
- We reviewed four medication administration records (MAR) and saw that there were no missed doses. Staff appropriately documented allergies and medicines reconciliations. A pharmacist verified and documented additional administration instruction.
- We observed staff administer medication and noted that appropriate checks were carried out first. Staff identified the correct drug chart and identified allergies before giving medication. Staff had mandatory medicine management training. Data provided by the trust prior to the inspection showed the attendance rate recorded was 71% for medical staff and 94% for nursing staff.
- Following the inspection, the trust informed us that the attendance rate for medicine management training was 96% for both nursing and medical staff at the time of the inspection. The trust's target for mandatory training was 90%.
- The critical care unit had a dedicated pharmacy team consisting of a Lead Pharmacist, supported by three other pharmacists and a pharmacy technician.
- A pharmacist attended a daily review of each patient and reviewed each patient's medications to ensure that they were suitable and within prescribing guidelines. The unit had good support from the pharmacy team and pharmacists attended daily multi-disciplinary team meetings.
- A temperature checking system was in place for refrigerated medicines. Fridge temperatures were monitored daily, however, minimum and maximum temperature were not recorded.
- Patient records (including medication records) were stored on the critical care unit's electronic documentation system. However, patients who came into the critical care unit from other departments came with an electronic prescribing and medicines administration (EMPA) chart that was then transcribed on to the units electronic system. This could result in drug transcription errors and delays to patients receiving the correct and timely drugs. This process was reversed when patients left the CCU for the wards leading to further risk of transcription error or delay.
- This was identified on the CCU risk register as a medium risk. The unit mitigates this risk by increased staff training, communication and awareness. In addition, pharmacists double checked entries in order to reduce transcription errors.
- The unit's quality and safety outcome board stated there were five medicines related incidents in the last month and no avoidable medicines omission.
- We found a drawn up syringe of medication in an unlocked drawer by the patient's bed space. We alerted staff, and this was appropriately disposed of.
- Between January 2015 and September 2015, results of the Trust's antimicrobial point prevalence audits showed that the critical care unit was 100% compliant with the guidelines on antibiotic usage. However, compliance fell to 84.6% between October 2015 and January 2016.

Records

- We looked at a random sample of 11 patient notes. All the records we looked at included details of allergies, a daily treatment plan and record of daily consultant reviews. Staff recorded specialist assessments, including assessments for nutrition, neurology and respiratory needs. The records showed input from multidisciplinary team including physiotherapists, dietician and tissue viability team. In addition, the records demonstrated consultants reviewed patients on admission to the unit and that daily consultant led ward rounds took place.

Critical care

- Staff demonstrated a good understanding of the need for confidentiality and we observed them using appropriate electronic password protected systems.
- Staff told us that the CCU was the only unit within the trust using an electronic patients' record system. They told us that patients were admitted from other departments with a paper-based record and visiting surgeons wrote in the paper file. Critical care staff recorded their assessments electronically thereby creating two parallel systems of patient records.
- We reviewed electronic notes, which showed that staff recorded details of patient medical history and a summary of the events requiring admission to CCU. We observed that most sections for visiting teams handing over a patient to the CCU were not completed on the electronic record. Although visiting teams provided verbal handover to critical care staff, there was a risk that instructions could be missed due to lack of documentation.

Safeguarding

- Staff were aware of their responsibilities in relation to safeguarding vulnerable adults and could locate and describe the trust safeguarding policy. A safeguarding booklet was visible within the unit on both sites.
- Staff escalated safeguarding incidents to the safeguarding team. Staff said the team members were visible and approachable. They could also report safeguarding incidents using an electronic system.
- 75% of administrative staff and all estates and ancillary staff completed level one adult safeguarding training. 68% of medical staff and 96% of nursing staff and 94% of additional clinical staff completed level 2 adult safeguarding training.
- All administrative staff and all estates and ancillary staff completed level one children safeguarding training. All additional clinical staff, 76% of medical staff and 98% of nursing staff completed level 2 children safeguarding training.
- The trust's target for safeguarding training was 90%.

Mandatory training

- The unit had a dedicated practice development and education team. 90% of all critical care staff achieved the trust target for all mandatory training modules.
- Mandatory training included adult basic life support, conflict resolution awareness, fire safety awareness, care of the back, moving and handling, safeguarding adult, safeguarding children, hand hygiene, infection control, information governance, medicines management, risk awareness, safe transfusion practices, inoculation incidents, treating people with respect and VTE.
- Staff spoke highly of their opportunities for training and said that it enabled them to keep up to date with best practice.

Assessing and responding to patient risk

- The critical care outreach service was a nurse led service providing 24 hours, seven days a week response to deteriorating patients. It included the patient emergency response and resuscitation team (PERRT) comprising of nine whole time equivalent nurses.The team provided a rapid expert response to acutely unwell patients in non-critical care areas, and support to patients on discharge from the critical care unit. The team also had access to consultants when required and a registrar is rostered with the team from 8am – 8pm on weekdays.
- The standard operating procedure sets out the criteria for referrals to PERRT. The PERRT team are expected to respond to referrals within 15 minutes.
- An audit of PERRT activities in 2015 shows that 91% of referrals were timely and 95% of referrals were responded to within 15 minutes. 95% of referrals had accurate National Early Warning Scores (NEWS) and 91% of referrals had all seven of the vital sign NEWS scores completed.
- There were 21 cases of delayed transfers to critical care or theatres out of 1802 patients in 2015. Whilst patients were waiting for an appropriate CCU bed they were kept in the recovery unit within theatres or the emergency department under the care of the PERRT team and outreach doctor.
- We observed one PERRT team handover and found it to be structured and detailed. The team discussed their referrals for the day and the action plan for each patient.

Nursing staffing

- A team of 203 nurses worked in the CCU, 130 of whom held a post-registration award in critical care nursing.

The percentage of nursing staff with post-registration award was better than the minimum recommended requirements of the Royal College of Nursing. In March 2016, there were 195.2 whole time equivalent (WTE) nurses on the unit. The established level of nurses required was 204.2 WTE.

- A matron led the nursing staff. There were five lines of nursing teams and a post-anaesthetic care unit (PACU) Team. A Band 7 critical care nurse led each line and staff were rostered to work at the two sites (T03 and Westmoreland Street). The matron, deputy matron and practice development nurse attended CCU at Westmoreland Street once a week.
- Senior staff told us they rarely used agency staff. The hospital's own bank staff were used to ensure that staffing levels remained safe. Temporary staff were required to go through an induction process to work on the unit. The service met the intensive care society standards for the appropriate acuity level of 1:1 care for level three patients and 1:2 care for level two patients.
- An acuity tool was used to determine staffing levels on the CCU. The patient activity and safety board provided information on the staff to patient ratio at T03. A similar board provided information on the staff to patient ratio at Westmoreland Street.
- Nursing staff conducted handovers twice daily with the whole team, at 8am and 8pm. We observed two handovers and found them to be structured, detailed and with a focus on personalised care. Nursing staff received an overview of all critical care patients at the start of their shifts and then a thorough bedside handover once they were allocated a patient.
- New nurses were initially supernumerary while becoming orientated to the department. They were allocated a mentor and received support from the practice development and education team. Staff who had started recently gave us positive feedback about the induction process.
- On one of the days of our inspection, there was only one supernumerary lead nurse on duty. Two of the lead nurses we spoke to said that they assisted patients when necessary. Senior staff informed us they intend to recruit an extra supernumerary lead nurse in line with best practice guidelines.

Medical staffing

- Two consultants provided cover between the hours of 8.00am and 5:30pm, Monday to Friday. Consultant cover on weekends was for eight hours on Saturday and eight hours on Sunday. An on-call consultant covered the night shift from 5:30pm to 8am. This met the intensive care society (ICS) standards requiring 24-hours a day, seven days a week consultant cover.
- A team of registrars, senior house officers (SHOs) and junior doctors supported the consultants on the unit. We saw copies of the medical staff rota and staff told us the cover was adequate. An additional registrar covered the PERRT team. Medical staff were on shift for 24-hours a day, seven days a week.
- Medical handovers took place every morning and evening. Doctors took part in the safety brief every morning and in a multidisciplinary team meeting at 12:30pm. Consultant led medical rounds were appropriate, with a full review of a patient's history, medicines and treatment.
- Staff told us that an airway-trained registrar was available 24 hours a day, seven days a week.

Major incident awareness and training

- There was an up to date major incident plan for the trust with an action card for the critical care unit. Senior staff told us that there was a plan to deal with surges in demand in the event of a major incident. This involved obtaining additional ventilators and medications. A senior nurse was in charge of the major incident planning. They attended trust wide meetings and participated in simulation sessions with local emergency services. However, none of the junior staff we spoke with were aware of this plan and their role in the major incidence response.

Are critical care services effective?

Good

We rated 'effective' as 'good' because:

- An experienced team of consultants and nurses delivered care and treatment based on a range of best practice guidance. Patients were cared for by appropriately qualified nursing staff who had received

an induction to the unit and achieved specific competencies before being able to care for patients independently. Medical staff received regular training as well as support from consultants.

- There was good access to seven-day services and the unit had input from a multidisciplinary team. Staff managed pain relief effectively and patients' nutrition and hydration needs were closely monitored.
- Staff at all levels had a good understanding of the need for consent and systems were in place to ensure compliance with the Deprivation of Liberty Safeguards.
- The unit had fewer readmissions within 48 hours of discharge and rarely transferred patients for non-clinical reasons.

However:

- The number of out of hours discharges were higher when compared to similar units and mortality rates were also slightly worse than other similar units.

Evidence-based care and treatment

- There were clear policies and procedures in line with best practice guidelines. However, junior staff were unable to show us where to access up to date policies. We highlighted this to senior staff and they informed us that all computers on the unit would be updated with direct links to local guidelines by the next working day.
- The CCU was part of the North East and North Central critical care network (NENC). Between May 2014 and May 2015, the NENC network self-assessment audit against London Quality Standards showed that the CCU met 25 of the 26 standards assessed. Each standard was assessed for compliance on weekdays and weekends. However, the unit failed to meet the standard requiring all emergency admissions to critical care to be seen and assessed by a consultant intensivist within 12 hours of admissions to the CCU on weekends. The trust response to improve this outcome was accepted by NENC as a satisfactory measure.
- Staff completed monthly audits of care bundles. We reviewed three months audit of compliance with critical care bundles. In February 2016, the unit scored 60% for implementing correct procedures in central venous catheter (CVC insertion), 100% for CVC on going care, 80% for peripheral cannula Insertion and 100% for peripheral line on-going care. The unit also scored 100% for ventilator on-going care, 100% for indwelling urinary catheter on-going care, 100% for preventing the spread of clostridium difficile, 100% for cleaning and decontamination of equipment and 80% for blood culture.
- All patients received daily physiotherapy as required by the NICE guidance and intensive care society standards. Rehabilitation progress was measured using validated outcome measures including the Chelsea Critical Care Physical Assessment Tool (CPAx), Functional Independence Measure and Function Assessment Measure (FIM+FAM) and John Hopkins Adapted Cognitive Exam (JH-ACE). Staff carried out physical morbidity assessments using CPAx and functional and cognitive assessments were carried out using FIM+FAM and JH-ACE.
- Staff told us that they conducted CPAx assessment on admission and after seven days. They told us they carried out FIM+FIM and JH-ACE assessments after two weeks. This was repeated at the time of discharge from CCU and then again at the time of discharge from the hospital.
- An audit against the trust's physiotherapy standards in September 2014 showed that 93% of patients had initial CPAx scored and rehabilitation goals set between seven to 14 days after admission. 98% of patients had weekly CPAx reassessments until they were discharged.
- An audit against the trust's physiotherapy standards in October 2015, showed that all patients at the greatest risk and able to engage in an assessment had initial FIM+FAM and JH-ACE scored and rehabilitation goals set from 14 days after their admission. There was also 100% compliance with the standard on discharge.
- There was an on-going programme of local clinical audits based on the needs of the unit. We identified 22 separate audits scheduled between August 2015 and August 2016, each managed by a named, dedicated member of staff. 11 of these audits have been completed with results presented to colleagues. In most cases, a re-audit was planned at an appropriate future point in time to check progress against the action plan.
- An audit on sleep promotion in critical care in February 2015 showed that out of 60 patients sampled, 56% indicated that they had poor sleep quality. The main factors identified were pain, anxiety, and noise. This led

to the implementation of a new protocol on the management of pain, sedation, delirium and sleep on the ICU. The policy specified that all adult patients should be assessed every four hours for pain and every eight hours for delirium. Patients should also be assessed hourly for agitation during the day and every four hours at night.

- The policy sets key principles to control pain first, use the minimum sedation necessary and optimise non-drug measures. Part of the key practices outlined, was to treat discomfort with careful positioning, give regular analgesia, maintain light sedation unless deeper sedation is required for clinical reasons and minimise light, noise and disturbance between 22:00 and 06:00 to encourage natural sleep. A re-audit in February 2016, identified the need for a simplified sleep assessment tool and better communication of the guideline to nursing staff.
- Staff had completed a clinical audit report on the experience of using high dose glucose-insulin-potassium (GIK) in critically ill patients with heart failure.Audits completed included "Nutrition–missing feeding times on ICU", oncology outcomes for critical care, outcome of pregnant and post-partum patients and enhance recovery of head and neck patients.
- Patients were assessed for their level of delirium by staff who used the Confusion Assessment Method (CAM) and the Richmond Agitation Sedation Scale (RASS).

Pain relief

- The CCU had dedicated pain nurse specialists on both sites and patients were assessed for pain throughout their stay. Patients also told us that they received pain relief when they required it and that it was reviewed regularly.
- Our review of patient records showed that staff used a standardised scoring tool to assess patients' pain and recorded pain assessments in patients' notes.
- There was a policy in place to provide guidance on pain management, agitation, delirium and sleep in CCU

Nutrition and hydration

- Our review of 11 patient records showed that staff completed nutrition and hydration assessment for each patient.
- The CCU had a dedicated team of dieticians on both sites during the week. The dieticians were core members of the multidisciplinary teams (MDTs) on both sites and a dietician attended and contributed to the daily MDT and ward rounds on weekdays. CCU dieticians maintained active links with the catering service and made requests for individual patients on the unit.
- All patients who required oral, enteral or parenteral nutrition were screened by dieticians on a daily basis and discussed with the relevant nursing or medical staff. an individualised nutritional assessment was undertaken. A comprehensive nutritional management plan was then documented and included in the patient's overall care plan.
- We observed patient meal times. Patients were enabled to eat independently and drinks were placed within their reach. We observed nurses assisting patients when required.
- Some patients told us that the food was lovely and they had a menu to choose from. However, some other patients said that they did not like the food.
- Between February 2015 and January 2016, the friends and family test result showed that the average rating for hospital food at T03 was 58%. This was lower than the benchmark of 75%. Overall, 86% of patients indicated that they get enough help from staff to eat their meals. This was again lower than the benchmark of 95%.
- Between August 2015 and January 2016, the average rating for hospital food at Westmoreland Street was 69%. Overall, 85% of patients indicated that they get enough help from staff to eat their meals.

Patient outcomes

- The unit contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. The latest ICNARC data available at the time of our inspection was for the period from April 2015 to 30 June 2015.
- ICNARC data for April 2015 to June 2015 showed that 46.1% of patients were admitted following elective surgery, 15.4% were admitted following urgent surgery and 9.3% were admitted from the emergency department.

Critical care

- In the period from April 2015 to June 2015, unplanned readmissions within 48 hours from unit discharge were better than similar units. Unplanned readmissions were 1.2% of 428 eligible admissions. This was 0.5% of 855 eligible admissions in the period between April 2014 to March 2015.Unplanned readmissions to similar units was 1.3% within the same period.
- There were no occurrences of non-clinical transfers out of the unit in the same period. This was also better than similar units which had 0.3% non-clinical transfers out.
- The mean length of stay on the unit for the period of April 2015 to June 2015 was 5 days. This was slightly longer than similar units (4.8 days).
- Patients discharged 'out of hours' between 10pm and 7am are associated with worse outcomes. There were 16 out of hours discharges or 3.8% of 426 patients discharged to a ward. ICNARC data analysis showed that this was worse than similar units which had 1.9% out of hours discharges to the ward. However, this was an improvement from the previous year between April 2014 and March 2015 when out of hours discharge was 11.1%.
- ICNARC data for April 2015 to June 2015 showed that unplanned admissions from the emergency department (8.9%) was lower than similar units (19.3%). Planned admissions following elective surgery (36.1%) was higher than similar units (31.2%), however, unplanned admissions following elective surgery (10%) higher than similar units (3.5%). Transfers from other critical care units (2.8%) were the same with similar units.
- ICNARC data for the period, April 2015 to June 2015 showed a high rate of unit-acquired infections in the blood (4.9). This was worse than similar units (2.2).
- Risk adjusted acute hospital mortality ratio was 1.23 (up from 1.02 in the previous period). This was worse than similar units (1.0).
- Risk adjusted acute hospital mortality ratio with a predicted risk of less than 20% was 1.19 (up from 1.04 in the previous period). This was slightly worse than similar units (0.9).

Competent staff

- The critical care unit had a dedicated practice development and education team consisting of two Band 7 nurses and three Band 6 nurses. The education team monitored nurse competencies on a rolling basis to make sure they were up to date with current practice based on national benchmark standards. Staff confirmed that they received email notifications to update their training.
- There were systems in place to ensure staff were competent to carry out their role. 80 new nurses were recruited in the last year. New nurses went through an induction programme to ensure that they were familiar with local policies and procedures, particularly in relation to medication administration, standards of patient care and assessment and record keeping. They were also required to complete competency-based assessments before they were allowed to work without supervision.
- New nurses were initially supernumerary while becoming orientated to the department. They were allocated a mentor and received support from the practice development and education team. After the allocated supernumerary period, the mentor and team leader would certify that the new starter is able to care for patients without supernumerary status. Staff who had recently started gave us positive feedback about the induction process.
- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post registration award in critical care nursing. 64% of the nurses had post registration qualifications in critical care and most of the new nurses we spoke to said that they were in the process of obtaining post registration qualifications in critical care.
- The responsibilities for nursing assistants were clearly set out and restrictions on the role were specified in induction materials.
- Junior doctors received an orientation and induction programme following their employment. Each junior doctor was allocated a clinical supervisor. All the clinical supervisors on the induction programme for 2016 were consultant intensivists.
- There were 16 consultant intensivists on the unit. The unit had a lead consultant and most of the consultants led in various areas. There was a named faculty tutor, educational supervisor for core trainees, educational supervisor for foundation doctors (FY2s) and a lead for

Westmoreland Street. In addition, the unit had a post-anaesthetic care unit (PACU) lead, an audit lead, a research lead, an innovation lead and an education lead.

- The lead consultant monitored the training and audit programmes of doctors to ensure that they implemented learning to improve practice. Medical staff used regular meetings, such as M&M and governance meetings with the critical care delivery group to review practice guidelines and identify areas of good practice and areas of improvement.
- At the time of the inspection, 80% of the Trust's doctors had their medical revalidations in place. All medical staff had undergone an appraisal between April 2015 and December 2015. However, only 70.6% of nursing staff had undergone an appraisal during the same period.
- We observed that there was a paediatric patient in T03 during the period of our inspection. Senior staff explained that they have a history of admitting adolescent cancer patients and occasionally take in paediatric patients. The patient's records showed input from a consultant paediatric oncologist, however, the nurses had not received any paediatric training. Senior staff explained that all nurses caring for the child were band 6 or above and they have a lot of support from the paediatric team. However, a review of the paper based medical records showed that there was no entry from visiting paediatric or surgical team since the patient's admission to the unit.

Multidisciplinary working

- Consultants led the critical care unit and doctors provided cover for 24 hours a day, seven days a week. There was regular input from visiting medical teams in the trust.
- Staff reported good working relationships with other teams. They told us multidisciplinary team members were approachable and visible on the unit. There were daily multidisciplinary team (MDT) safety brief and staff shared learnings about potential problems and concerns so that the team could improve on patient safety and experience. Nursing and medical staff, pharmacists, physiotherapists and dieticians attended the MDT meetings. There was also a weekly MDT meeting to discuss rehabilitation for long stay patients.
- A team of four physiotherapists and one therapy assistant provided cover to the critical care unit. The physiotherapy team prioritised and assessed patients on the unit daily. The physiotherapy team also provided training to staff on the on-call rota. Physiotherapy on-call cover was available 24 hours a day, seven days a week.
- The critical care unit had a decided pharmacy team consisting of a Lead Pharmacist, 3 pharmacists and a pharmacy technician. Pharmacists worked closely with nursing and medical staff and reviewed each patient's medication daily to ensure that they were suitable and within prescribing guidelines.
- A team of four dieticians provided cover to the critical care unit during weekdays. They assessed nutritional and hydration needs and made requests to the catering team on a unit and individual basis.
- Pain nurse specialist worked with nursing staff to access patients' pain on the unit. Staff had access to the speech and language therapy (SALT) team and occupational therapy (OT) on a referral basis.
- We attended a MDT meeting, two nursing handovers and one medical handover. The meetings were structured and detailed with a focus on personalised care.
- The Patient Emergency Response and Resuscitation Team (Critical Care outreach team) (PERRT), at UCH and at the Westmoreland site follows up patients discharged from Critical Care on T03 and at Westmoreland site.
- The critical care service recognised that activity being achieved was also dependent upon the 'Flow' of patients within the tower and at Westmoreland Street. If there was not an appropriate speed of discharge facilitated in order for the unit to discharge patients to their host ward once they are deemed ready, there was a subsequent pressure and inability to admit the next patients. Senior managers recognised that this would continue to be a focus requiring continued monitoring of Post Anaesthetic Care Unit (PACU) patient flow to meet demand for beds. While we saw the recognition of the need to manage this we did not see evidence of formal discharge protocols in use.

Critical care

- The trust informed us there was a scheme of work looking at improving the clinical coordination function and ward discharge processes under UCLH futures programme.
- Patients who have stayed on the unit for three or more days were invited to attend the critical care follow –up clinic. However, any critical care patient may have an appointment should they wish to have one. The follow–up clinic was consultant-led but patients were also seen by a clinical nurse specialist and had access to a clinical psychologist.
- The CCU was part of the North East and North Central critical care network (NENC) and staff from the CCU regularly attended network meeting to share practice and learning.

Seven-day services

- Medical and nursing staff provided cover on both sites for 24-hours a day, seven days a week.
- Two Consultants provided cover between the hours of 8am and 5:30pm, Monday to Friday. One of the consultants worked until 6:30pm during the week. Consultant cover on weekends was for eight hours on Saturday and eight hours on Sunday. An on-call consultant covers the night shift from 5:30pm to 8am every day.
- A team of registrars, Senior House Officers (SHOs) and junior doctors supported the consultants on the unit. An additional registrar covers the PERRT team.
- However, a network self-assessment audit against London Quality Standards showed that the CCU failed to meet the standard requiring all emergency admissions to critical care to be seen and assessed by a consultant intensivist within 12 hours of admissions to the CCU on weekends. This was for the period between May 2014 and May 2015.
- The dietetic teams provided cover during week days. The physiotherapy and pharmacy teams provided cover for seven days a week and an on-call service for 24 hours.
- The CCU had access to specialist imaging including 24 hours a day, seven days a week interventional radiologist cover.

Access to information

- Staff received a verbal and written handover when patients were admitted to the ward. On discharge from critical care, a medical discharge summary was written and verbal handover to the receiving team was provided.
- Staff had access to patients' care plans, risk assessments and case notes on the CCU electronic system. Staff also had access to patients' paper file containing assessments, test results and other patient records taken prior to their admission to the CCU.

Consent and Mental Capacity Act (include Deprivation of Liberty Safeguards if appropriate)

- Staff had access to best practice guidance and local mental capacity policies on the unit. Staff could access mental health/deprivation of liberty safeguards guidelines from their mobile phone through a trust wide application.
- Staff were able to talk about the deprivation of liberty safeguards and how this would impact a patient on the unit. Staff were aware of their responsibilities under the mental capacity act.
- Staff were able to tell us how they would obtain consent and where consent could not be obtained, staff told us care was provided in the patient's best interest. Staff also routinely re-assessed capacity whenever a person's condition improved, in line with relevant guidelines.
- Staff informed us they held MDT meetings to discuss the care of patients without capacity. Persons legally responsible for the patient were invited to attend.
- Staff had access to best practice guidance and local mental capacity policies on the unit. Staff could access mental health/deprivation of liberty safeguards guidelines from their mobile phone through a trust wide application.

Are critical care services caring?

Good

We rated 'caring' as 'good' because:

Critical care

- The critical care unit provided a caring, kind, and compassionate service, which involved patients and their relatives in their care. All the feedback from patients and their relatives was positive.
- Observations of care showed staff maintained patients' privacy and dignity and patients and their families were involved in their care.
- Staff provided emotional support to patients and patients were able to access the hospital multi-faith chaplaincy services, when required. Additional support from a clinical psychologist was available to patients.
- Patients' feedback was sought and the latest yearly friend and family test results showed 95% of patients would recommend the CCU.

Compassionate care

- Patient, family and friends feedback in both units was mostly positive. Patients said they had received "very good care" and described nurses as "friendly", "lovely" and "accommodating". They described consultants as "amazing consultants". Patients and relatives gave many "thank you" cards and some poems that staff put on the notice boards on both sites.
- All observations of care we made were positive, showing kind and compassionate care. We observed nurses assisting patients to the bathroom and helping to make patients more comfortable. In one instance, we observed a nurse provide a patient with a pillow to rest his arm.
- We observed staff interactions with patients. Staff were courteous, professional and engaging. We saw staff maintaining patient privacy and dignity by drawing the curtains around patient areas before completing care tasks.
- Patients said that they were safe in the unit and their pain was well managed. They said staff explained procedures and obtained their consent before conducting them. They said staff responded quickly when they called for them. Relatives were also happy with the care provided; both patients and relatives said staff were visible and caring. Patients said they had no complaints and the service was impeccable.
- 423 patients in T03 completed the friends and family test between February 2015 and January 2016. 95% of those patients said they would recommend the unit to their friends and family.
- 132 patients in Westmoreland Street completed the friends and family test between August 2015 and January 2016. 93% of those patients said they would recommend the unit to their friends and family.

Understanding and involvement of patients and those close to them

- Patients and relatives reported they were involved in their care and were given explanations about their treatment. Patients said staff introduced themselves before attending to them. They explained the procedure they were about to carry out and the risks were discussed. Patients felt involved in their care and decisions and described the team as courteous and polite.
- Doctors provided updates to patients and relatives on ward rounds. For more detailed and confidential explanation, they agreed a time to speak with the family in a separate quiet room. One of the doctors we spoke with said he addressed patients and their relatives by name and always provided them with updates when he visited. Patients said they were empowered by the information provided to them by doctors.
- Comments from the friends and family test indicates that staff listen to patients' advice on how to care for them.
- Staff documented the assessments made and the discussions held in the patients notes.

Emotional support

- A multidisciplinary team including doctors, nurses, physiotherapists, pharmacists and a dietician supported patients on the unit. The unit had a follow up clinic and a clinical psychologist to supported patients recovering from illness. Patients also had access to a clinical nurse specialist.
- Emotional support was also provided by the multi-faith chaplain service within the hospital and representatives from various faith groups could be accessed.

Are critical care services responsive?

Good

We rated 'responsive' as 'good' because:

- The senior staff had an understanding of the needs of the service and patients and worked well with other specialities to facilitate access to the CCU.
- The majority of patients were admitted within four hours of the decision to admit and data showed there had been no patients transferred for non-clinical reasons.
- Staff had access to communication aids and translators when needed, giving patient the opportunity to make decision about their care, and day to day tasks.
- Quiet rooms were available for staff to speak to relatives and relatives had access to a relatives' room.
- There were very few complaints about the services and staff dealt with complaint appropriately.
- Delayed discharges were better when compared with similar units and did not currently impact on admissions to the unit.

However:

- There was no flagging system for patients living with dementia or with learning disabilities so it was unclear how staff identified these patients and adapted their care accordingly.
- There was lack of relevant information available in relatives' room such as chaplaincy services or specialist charities offering emotional support.
- The unit had a higher number of out of hours discharges when compared to similar units.

Service planning and delivery to meet the needs of local people

- The CCU opened an additional nine bedded unit at Westmoreland Street in June 2015 to support thoracic and urological surgery. Staff were rostered to provide care in both units and there been positive feedback from staff and patients.
- A follow up clinic was available for patients to attend after they were discharged from the units. Discharge summaries from the CCU were sent to family doctors (GPs).
- There was a quiet room available for relatives at T03 and the doctors could discuss confidential information in with relatives. There was a larger relatives' room with bright and lovely mural on the wall. The room had comfortable sofas, with provisions for water, tea and coffee. The room was equipped with a microwave, a kettle and disposable cups.
- There were leaflets in the relative room providing information about preventing surgical wound infections, C.diff, isolation procedures and review of epilepsy care. In addition, there was a patient and visitor comment card. However, there were no leaflets providing information on how to access the chaplaincy, how to make a complaint or how to access emotional support through specialist charities.
- Some relatives told us that they could not find leaflets with relevant information. One relative told us that she had to go to a local cafe in order to access information about tracheotomy on the internet.
- There were no facilities for relatives to stay overnight but they were able to ring the unit for updates.
- There were limited facilities for relatives at Westmoreland Street. There was a one relatives' room for both the recovery unit and the critical care unit. There were no arrangements in place for food and drink in the room, however, visitors could access a café within the hospital. There were leaflets providing information about raising a complaint, keeping adults safe from abuse, controlling hospital infections and MRSA test before surgery.
- A relative told us that they could not spend enough time with the patient due to inadequate parking facilities at Westmoreland Street. There were no facilities for relatives to stay overnight at the unit.
- Majority of the admissions to the critical care unit between March 2015 and March 2016 were unplanned admissions, although the unit also admitted patients following elective surgery. The unit received patients from the Accident and Emergency Department, theatre and wards. 2.7% of the admissions were transfers from other critical care units.

Meeting people's individual needs

- Staff provided patients a welcome pack on admission. The pack contained a welcome book, a pen, earplugs, an eye patch and non-slip socks. The welcome book provides information about VTE, hygiene, privacy and dignity, food and drink, chaplaincy and spiritual care,

library service, consent and information about the patient advice and liaison service (PALS). It provided information about pain control and patients were encouraged to let staff know when they were in pain. It also provided information about how to identify nurses by their uniform. It encouraged patients to talk if they had any worries or fears.

- The trust recognised the diversity of its local population and provided access to interpreting service 24 hours a day, seven days a week. This was provided through a telephone language line and face to face interpreting and translation service. Staff on the critical care unit confirmed that they could access interpreting service for patients through a help line. Senior staff told us that they could also request for face-to-face interpreting services when required.
- The trust offered counselling services to patients. Staff told us they arranged for patients to access this service when requested.
- There were three patient bathrooms on the CCU at T03 and staff assisted patients to the bathrooms to have a shower.
- Patients told us that they felt safe on the units and they had adequate pain relief in a timely manner. Patients told us that their relatives had access to visit and they could receive phone calls from relatives.
- Physiotherapists facilitated patient rehabilitation and assisted them to go out of the unit. One of the patients we spoke to said he had a planned appointment with a physiotherapist for that purpose.
- It was not clear how patients living with dementia were identified and we did not see evidence of any relevant documentation in the patient notes.
- We observed a patient with learning disability on the CCU. The patient had not been reviewed by a learning disabilities nurse and there were no appropriate care plans in place such as a hospital passport. Senior staff told us that they involve families of patients with learning disabilities in their care on the unit and the families guide staff to engage with the patients.

Access and flow

- Proposed admissions to the CCU were reviewed by a critical care team including a consultant. The team consulted the nurse in charge to ensure staffing levels were adequate.
- The PERRT Data Audit showed that 89% of patients were admitted to CCU within four hours of referral to PERRT in the last year.
- ICNARC data for April 2015 to June 2015 showed there had been 137.8 delayed discharges of less than eight hours, or 4.3% of 3185 total number of available bed days in the unit. This was better than similar units nationally. This also was an improvement from the previous year when delayed discharges was 6.6%.
- There were no occurrences of non-clinical transfers out of the unit in the same period. This was also better than similar units nationally.
- There were 16 out of hours discharges or 3.8% of 426 patients discharged to a ward. These are discharges occurring during the hours of 10pm and 6:59am. ICNARC data analysis showed that this was higher than similar units which had 1.9%.
- Staff told us delayed discharges occurred due to lack of bed availability in the rest of the hospital. Sometimes patients have to go to a specialist ward but there were no available beds in that ward. Staff reported the situation had improved over time and they prioritised admissions of high-risk critically ill patients into the unit. Senior staff told us that they care for patients in the recovery unit or emergency department when there are no available beds on the unit.
- In the last 12 months, there were no occurrences of patients ventilated outside the critical care unit due to lack of bed spaces in critical care.
- Although T03 is a 35 bedded unit, it is only funded for 31 beds. Data received from the trust showed an average of 29 beds were occupied on T03 between 5 March 2015 and 4 March 2016. This averaged between 32 to 35 beds in the last three months. This figures showed that the demand exceeded the number of funded beds.
- An average of six beds were occupied on Westmoreland Street between 5 March 2015 and 4 March 2016.
- Data provided by the trust showed that 34 elective surgeries were cancelled in the last year due to the lack of critical care beds.

Critical care

Learning from complaints and concerns

- There had been no formal complaints in the 11 months prior to our inspection. Staff explained that they escalated complaints to the matron. Senior staff provided feedback to everyone involved and shared learnings with the team. Staff told us that they ensure that patients are comfortable and encourage them to express any concerns that they have. Most concerns raised by patients or relatives were dealt with informally on the unit by staff.
- We reviewed minutes of staff meetings in the three months leading to our inspection and saw that complaints and incidents were discussed and action points were raised. For instance, a senior staff informed the meeting about an informal complaint from a family regarding a procedure. The medical team had met with the family and they were satisfied with the explanations given.
- We saw leaflets providing information on how to make a complaint in the reception area at T03 and in the relatives' room at Westmoreland Street. The leaflets provided details of the complaint department and PALS. However, the leaflets were not very visible throughout the unit.

Are critical care services well-led?

Good

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

- The leadership team had a clear vision and strategy and staff were able to verbalise future plans. There was a robust governance structure, both within critical care and within the directorate.
- We saw good local leadership within the unit and staff reflected this in their conversations with us. Staff said the culture on the unit was very open and any member of staff could approach the leadership team with any issues or new ideas.
- There was evidence of staff engagement and changes being made as a result.
- Patients were engaged through surveys, feedback forms and a quarterly patient forum.
- The unit was engaged in research and there was a large team of nurses and doctors dedicated to the research programme.
- The management team had oversight of the risks within the services and mitigating plans were in place.

However:

- The unit occasionally admitted paediatric patients but staff did not have paediatric training. This was not recorded on the risk register even though senior staff told us they considered it as a risk.

Vision and strategy for this service

- The unit's vision and strategy was driven by the wider vision of the trust to deliver 'top-quality' patient care, excellent education and world class research.
- The CCU divisional business plan for 2014 to 2016 identified eight key divisional objectives for the service with a named lead for each objective. The objectives included improving patient safety, delivering excellent clinical outcomes, reducing waiting times, achieving sustainable financial health, transforming patient pathways, developing research and education, enabling staff to maximise their potential and progressing service developments and key strategic developments.
- The unit identified its priority performance target for 2014/2015. This was to develop and monitor outcome metrics including standardised mortality rates, infection rates and patient satisfaction outcomes.

Governance, risk management and quality measurement

- The CCU was governed under the medicine board and led by a divisional clinical director.
- The clinical director and a multidisciplinary team of consultants, senior nursing staff and allied health professionals attended monthly clinical governance meeting. Staff discussed incidents, risk management, policies, audits, staffing and other performance issues meeting and raised action points following each meeting. Information and feedback from the governance meeting were disseminated to staff during handovers, MDT meetings, safety huddles and through the safety bulletin.
- Senior staff also attended a monthly senior staff meeting where they discussed activity updates, plans,

guidelines, cost improvement plans and staffing. Senior staff extensively discussed responsibilities under the duty of candour during a meeting held on 5 October 2015. Training workshops were organised for staff from October 2015 to December 2015.

- Minutes of the meetings show that there were cost improvement initiatives in place. Senior staff informed us there was no adverse impact on patient safety.
- There was a monthly mortality and morbidity meeting with a focus on quality improvement and improving patient outcomes post critical care.
- In August 2015, the CCU and the Emergency services presented the Emergency Services and Critical Care Deep Dive to the Medicine Board. The key highlights for the CCU was opening of the nine bedded unit at Westmoreland Street and the environment and storage project at T03. The CCU outlined its quality enhancement initiatives for 2015 to 2016.
- There was a programme of clinical and internal audits, which staff used to monitor quality and systems to identify action plans. In the last 12 months, staff carried out re-audits to check progress against the action plan in previous audits.
- The unit maintained a risk register, including concerns and assessments of potential risks on the unit. Mitigating plans were put in place. Senior staff routinely discussed risks at clinical governance meetings and identified them on the divisional business plan.
- However, the risk of adult nurses looking after paediatric patients without appropriate training was not identified on the risk register.
- In addition, we identified issues on the risk register, which had already been corrected by the time of our inspection. For instance, unlocked fridges were identified as a medication security risk on the risk register. Staff updated the risk register in January 2016 to reflect that they had ordered lockable fridges. Lockable fridges were already in use during our inspection in March 2016.

Leadership of service

- The critical care service was led by a clinical director, divisional manager, general manager, matron and consultant nurse.
- Staff told us they were supported by senior management in critical care including the divisional clinical director, matron and general manager. Staff told us that the senior management were approachable and visible on the unit.
- Lines of accountability and responsibility in the unit were clear and staff understood their roles and how to escalate problems. There were five lines of nursing teams and a Post-Anaesthetic Care Unit (PACU) Team. A Band 7 critical care nurse led each nursing line. Nurses told us that the matron was visible and aware of all incidents. Senior staff fed back results of incidents to staff through the morning brief safety huddles and safety bulletins.
- Junior doctors told us that the unit functioned well and that consultants took ownership and gave clear directions to them. They said they were valued and described the CCU as a good work environment.

Culture within the service

- Senior nurses on the unit told us that they found the directorate's leadership team approachable and responsive to communication.
- Staff told us that there was a positive culture on the unit and they were happy to work on the unit. They confirmed that they have good working relationships with other team members within the unit. There was good multidisciplinary team working in place and staff said they worked well with consultants.
- Staff said that the unit was open and transparent and they could raise any concerns with senior staff. Staff understood their responsibility under the duty of candour regulations and followed the correct process. Information about the duty of candour process was displayed on the staff communication board and training workshops were organised for staff between October 2015 and December 2015.

Public engagement

- Relatives and patients told us they were involved in care and treatment decisions and the level of information given to them was clear and adequate. Patients also had access to a follow up clinic following their discharge from the CCU.
- Senior staff told us that they involved patients in care delivery through the Critical Care Patient Forum. This

forum meets quarterly and ex-critical care patients were invited to the meeting. The unit provide information about their vision and progress and the patients discussed any issues they want to raise.

- The unit also monitored patient satisfaction from patient surveys, comments and feedback forms. Outcome from patient surveys were provided on the quality and safety board within the critical care unit. The unit highlighted what was good, what they needed to improve and what they were doing about it.

Staff engagement

- Staff survey results were generally positive. The CCU staff survey results for 2015 showed that 95.83% of staff would recommend the CCU as a place to work. 90.63% indicated that the standard of care in the unit is to the standard of care that they would want for a loved one. 93.68% of staff were satisfied with the quality of care they gave to patients, relatives and loved ones.
- The NHS staff Survey for the same period identified that for the 'staff engagement' metric CCU was in the top 5% in the NHS and 98% of staff believe that their role makes a difference.
- Staff said they were engaged and said they could express concerns to their team. Staff said they were in a fantastic team and were committed to improving patient care. One of the staff said she was "blessed" by having such a great team.
- Staff said they were adequately supported by senior staff and new staff were paired with mentors. Black and minority ethnic (BME) staff said that there were equal opportunities for everyone irrespective of their disability, race, sexuality, culture or gender. Senior staff told us that 60% of the sisters in charge were BME staff and there was a diversity of people in the administrative team with equal opportunities for everyone.
- Management disseminated information to staff through the safety huddles, staff board and face-to-face meetings.
- The unit had a coffee room for staff to relax during their break.

Innovation, improvement and sustainability

- Over the last six months, the CCU has undertaken an environment improvement project at T03 aimed at reducing the stress patients and their relatives experience whilst in the unit, in addition to improvements in the storage across the floor. We observed the improvements made during our inspection and found that each bay had a good layout and was well equipped to deliver patient care.
- There were similar patterns of working on both sites. Nursing staff were positive about their experience of working on both sites. Senior staff told us that teams outside critical care had been briefed to provide services at Westmoreland street and the unit works well with no problems of patient deterioration due to lack of opinion.
- The CCU was actively involved in research. The clinical research team was composed of four full time research nurses and two consultants, one of whom is the research hub lead. The team run clinical studies ranging from questionnaires on oral health, through studies on nurse led psychological intervention to early phase drug trials.
- The trust is the lead centre for the Critical Care Health Informatics Collaborative. This project aims to link routine healthcare data across trusts to improve clinical research and outcomes.

Maternity and gynaecology

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

Information about the service

University College Hospital London (UCLH) NHS Foundation Trust provides maternity and gynaecology services from the Elizabeth Garret Anderson Wing (EGA). The building opened in 2008.

The maternity and gynaecology service at University College Hospital London NHS Foundation Trust is part of the Women's Health Division, which also provides fetal medicine, gynaecology, reproductive medicine, breast and neonatal services.

A total of 6,541 babies were born at the Elizabeth Garret Anderson Wing in 2015.

The Elizabeth Garret Anderson Wing provides maternity and gynaecology services over four floors. Gynaecology services including the Early Pregnancy Unit are located on the lower ground floor. Maternity services are provided over three floors. The first floor has an integrated antenatal clinic area consisting of fetal medicine unit, maternal assessment unit, 14 consulting rooms and a number of ultrasound examination rooms. The second floor has a labour ward with 12 birthing rooms, four bedded close observation area, two theatres and one birthing pool. The third floor has a ten bedded antenatal ward, 46 bedded postnatal ward and a seven bedded birthing unit with two birthing pools.

The maternity service at University College Hospital London offers: a consultant-led labour ward; birth centre; an outpatient antenatal and gynaecology clinic; a fetal medicine unit (FMU); a maternal fetal assessment unit (FMAU); a triage unit; antenatal and postnatal inpatient wards. Women can also choose to have a home birth supported by community midwives. The maternity services (in conjunction with Great Ormond Street) provide specialist provision for women for prenatal diagnosis of for example cardiac anomalies

The gynaecology services at the University College Hospital London offer inpatient care, outpatient care and emergency assessment facilities, including an Early Pregnancy Assessment Unit (EPAU). Outpatient care includes colposcopy, hysteroscopy, treatment for miscarriage, termination of pregnancy services and pre-operative assessment. A team of gynaecologists receive support from specialist gynaecology nurses, general nurses and healthcare assistants.

Gynaecology in patient activity takes place on T6. This report focuses on gynaecology specific pathways.

Examinations, scans, treatment plans and assessments were carried out in the gynaecology outpatients during the week. A team of professional staff supported patients in investigative procedures, giving advice as necessary. Emergency scans and assessments were available out of hours. We were told that there was a gynaecology operation scheduled on most days.

Patients were offered a choice of medical or surgical treatment for termination of pregnancy.

The trust provided activity data for March 2015 to February 201 that demonstrated the following:

- GP referrals – 13437
- Consultant referrals – 4406
- Other referrals – 3636

Maternity and gynaecology

- New attendees – 19167
- Follow up attendees – 27316
- Day case – 1221
- Outpatient Procedures – 33115
- Elective Procedures – 2540
- Non-elective procedures 591

We visited all wards and departments relevant to the services. For maternity services we spoke with 14 patients, two relatives, 16 midwives and support workers individually. For gynaecology services we spoke with four patients and five nurses. We also spoke with 14 medical staff who worked across both maternity and gynaecology services.

There was a statement of vision and strategy and staff we spoke with demonstrated an awareness or understanding of it.

We observed that vital roles such as the labour ward coordinator, even though planned to be supernumerary, sometimes proved not to be.

There were good clinical multidisciplinary working relationships. Leaders were described as visible and approachable.

It was reported to us by a number of members of staff that there were individuals amongst the work force who exhibited challenging behaviour at times. We saw evidence that the Divisional Management team were aware of these issues and implement strategies to work with the individuals involved to modify these traits.

We rated safety in maternity and gynaecology as good because:

- Escalation of risk was identified through a computer based incident reporting system, Datix. Incidents are flagged via Datix to clinicians and the exec team. This allows them to question the clinical teams and review the incident to gather all information. The nationally recognised Royal College of Obstetricians and Gynaecologists (RCOG) trigger tool was used for incident reporting. We were told that all incidents were reported in line with the RCOG Clinical Governance Advice No.2, Improving Patient Safety, Risk Management for Maternity and Gynaecology and NHSE Serious Incident Framework.
- There was a strong reporting culture in both maternity and gynaecology. We saw that 1314 maternity and 81 gynaecology incidents were reported between April and November 2015.
- We observed compliance with the trust infection prevention and control policy. We saw that staff used hand gel, protective clothing and adhered to the bare below the elbow policy. The 'Quality and Safety' boards in all the clinical areas within EGA demonstrated that there was 100% compliance with hand hygiene .On T6 (Gynaecology) hand hygiene compliance was recorded as 85%.
- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and national and local policy.
- We saw a safe staffing board that demonstrated planned staffing met actual staff ratios for each shift. The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendation.

We rated effective in maternity and gynaecology as good because:

- Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care. Care and treatment reflected current evidence-based guidance.
- Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care for example, a review of caesarean section rates.
- Women we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24-hour period.
- Staff were competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working in the maternity service. Staff worked collaboratively to serve the interests of women across hospital and community settings.
- Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.

Maternity and gynaecology

- We saw examples of outstanding world class practice, notably the One Stop first trimester Down's syndrome Screening clinic with immediate Fetal Medicine referral, the gynaecology Integrated 'One Stop' Diagnostic and Testing service, and the see and treat service in colposcopy. Surgical management of miscarriage under local anaesthetic in the Early Pregnancy Unit and integrated multi-disciplinary working within the Fetal Medicine Unit were also examples of outstanding practice.

We rated caring in maternity and gynaecology as good because:

- Feedback from patients and those close to them was positive. Overwhelmingly we received feedback that care was excellent and compassionate. Women reported being treated with dignity, respect and kindness during all interactions and patient-staff relationships were very positive.
- Patients were involved and encouraged to be partners in their care and were supported in making decisions. Both maternity and gynaecological patients told us that they felt well informed, understood their care and treatment and were able to ask staff if they were not sure about something.
- Midwifery staff responded compassionately when patients needed help and supported them and their babies to meet their personal needs. Staff helped patients and those close to them to cope emotionally with their care and treatment.
- Patient's spoke highly of the nursing staff on the gynaecology ward and told us care had been 'really good'.

We rated responsive in maternity and gynaecology as good because:

- Patients' individual needs and preferences were considered when planning and delivering services.
- Whilst a room on labour ward had been dedicated as a bereavement room, capacity issues within the service meant that this room was frequently used as a labour room which meant that a woman and her partner could be cared for on the main labour ward.
- The maternity service was flexible and provided choice and continuity of care.
- The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support people with particular needs.
- Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

We rated well-led in maternity and gynaecology to be good because:

- There was a statement of vision and strategy and staff we spoke with demonstrated an awareness or understanding of it.
- We observed that vital roles such as the labour ward coordinator, even though planned to be supernumerary, sometimes proved not to be.
- There were good clinical multidisciplinary working relationships. Leaders were described as visible and approachable.
- It was reported to us by a number of members of staff that there were individuals amongst the work force who exhibited challenging behaviour at times. We saw evidence that the Divisional Management team were aware of these issues and implement strategies to work with the individuals involved to modify these traits.

Maternity and gynaecology

Summary of findings

Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care. Care and treatment reflected current evidence-based guidance.

Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care for example, a review of caesarean section rates.

Women we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24-hour period.

Staff were competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working in the maternity service. Staff worked collaboratively to serve the interests of women across hospital and community settings.

Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.

We saw examples of outstanding world class practice, notably the One Stop first trimester Down's syndrome Screening clinic with immediate Fetal Medicine referral, the gynaecology Integrated 'One Stop' Diagnostic and Testing service, and the see and treat service in colposcopy. Surgical management of miscarriage under local anaesthetic in the Early Pregnancy Unit and integrated multi-disciplinary working within the Fetal Medicine Unit were also examples of outstanding practice.

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Maternity and gynaecology

Are maternity and gynaecology services safe?

Good

Incidents

- We were assured that the trust approach to incident management was timely and enabled quick mitigation of the risks relating to the health, safety and welfare of service users.
- Staff told us that they were able to raise concerns and were confident that their concerns were listened to.
- Escalation of risk was identified through a computer based incident reporting system, Datix. Incidents are flagged via Datix to clinicians and the exec team. This allows them to question the clinical teams and review the incident to gather all information. The nationally recognised Royal College of Obstetricians and Gynaecologists (RCOG) trigger tool was used for incident reporting. We were told that all incidents were reported in line with the RCOG Clinical Governance Advice No.2, Improving Patient Safety, Risk Management for Maternity and Gynaecology and NHSE Serious Incident Framework.
- There was a strong reporting culture in both maternity and gynaecology. We saw that 1314 maternity and 81 gynaecology incidents were reported between April and November 2015
- We saw that all Datix incidents were reviewed daily by the Site Manager who liaised with departmental matrons and the Governance Midwife. Incidents which were classified as moderate to high risk were reviewed by the Governance midwife who prepared a timeline to examine service and/or care provision problems to present at a weekly Clinical Incident Review Group (CIRG). On average six to eight cases are reviewed at each meeting which has a multi disciplinary approach We saw that seven incidents were rated at the CIRG meeting as Serious Incidents and were reported to the trust's Central Risk Department who decided what was reported externally.
- Incidents were discussed at a weekly clinical incident review group meeting and allocated to an incident manager if it was considered that further investigation was required.
- Following investigation or RCA the SI was discussed by the clinical Incident review group (CIRG) who made a judgement and decided on recommendation and actions
- We saw a sample of completed investigations, which were robust and demonstrated that lessons learned had been identified.
- We saw documentary evidence that action plans were drawn up in response to lessons learned. Action plans were kept under review at the monthly local risk management group/clinical governance meetings
- We saw examples of the weekly newsletter which included key messages from reviews of incidents which had not been classified as serious incidents. For example a message regarding not giving a specific date for post-mortem results to avoid unnecessary distress to parents. In addition key messages were conveyed via the monthly 'Big 4 Safety Huddle' Key messages are developed which were pertinent to individual clinical areas. For example in Labour Ward: the messages related to the importance of sending placentas for histology in cases where babies whose birth weight is small for gestation, applying a fetal scalp electrode and obtaining a second opinion if the CTG is of a poor quality, ensuring that staff check blood results, recordkeeping and emergency equipment checking.
- We also saw evidence that incidents were scrutinised to review any emerging themes. An example of this related to the definition of latent phase of labour. As a result the guideline relating to the latent phase of labour was modified to include that if a woman was contracting regularly but had not achieved a cervical dilatation of 4cms that she should be monitored the same as a woman in established labour. A further outcome of the thematic review was that midwives were not identifying changes in the baseline rate on intermittent auscultation of the fetal heart primarily because the partogram (graphical record of key fetal and maternal observations during labour) had been redesigned utilizing a Modified Early Warning Score (MEOW's) approach.

- Staff told us about changes that had been made in response to lessons learned. A theme from SIs was the interpretation of cardiotocography (CTG) recordings of the fetal heart. For example the trust was part of the ongoing work of the North Central London Maternity and Newborn Network to introduce the International Federation of Gynaecology and Obstetrics (FIGO) consensus guidelines on intrapartum fetal monitoring that were published in October 2015. However the Trust had decided that as the National Institute of Clinical Excellence (NICE) were planning a further review of the national intrapartum guidance that local policy and guidance would still continue based on the 2007 guidance until national consensus was reached and thus avoid confusion for staff. To embed learning from incidents which had involved interpretation of CTGs the service had implemented compulsory half days session for all staff. The training involved simulated scenario based training of CTG interpretation which was formally assessed with clear action plans if staff failed the assessment. A weekly meeting of review of CTGs was also held in which all grades of staff were encouraged to attend.

Duty of Candour

- We saw a sample of completed investigations, which were robust and demonstrated that lessons learned had been identified and duty of candour observed.
- We were told by managers that, when necessary, women and those close to them were involved in reviews they ensured that requirements under the duty of candour were met. We saw from a RCA that parents had been given a verbal apology and that a duty of candour letter had been sent offering them the opportunity to participate in the investigation.

Safety thermometer

- The Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care. It is intended for public display so that the public are informed about the level of harm free care they can expect. The Maternity Safety Thermometer measures harm from perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. It also records babies with an Apgar score of less than seven at five minutes and/or those who are admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score. The trust recorded but did not display all the metrics of the national maternity safety. This meant that the public could not readily see the harm specific to maternity care that they may expect to experience.
- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism.
- We saw 'Quality and Safety' information boards for February2016 in all clinical areas.
- On the Gynaecology Quality and Safety Board we saw that it had been 32 days since the last recorded instance of a patient falling, there had been no pressure ulcers or medication errors and the ward had not received any complains in the last month.

Acuity Tool

- Acuity tools are used to measure and respond to capacity on the delivery and indicate to staff when the escalated policy should be used to ensure the safety of women and their babies.The maternity unit had 24 hour site manager cover who carried a bleep in order to manage the response required to changes in acuity and activity.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and well maintained. However we did some light dust at high levels. An external company was responsible for cleaning and we saw cleaning schedules on all wards.
- We saw that equipment was labelled with tags to indicate when it had been cleaned. Sluice areas were clean and had appropriate disposal facilities, including for disposal of placentas. The blood gas analyser on Labour Ward did have some light blood spillage.

- We observed compliance with the trust infection prevention and control policy. We saw that staff used hand gel, protective clothing and adhered to the bare below the elbow policy. The 'Quality and Safety' boards in all the clinical areas within EGA demonstrated that there was 100% compliance with hand hygiene .On T6 (Gynaecology) hand hygiene compliance was recorded as 85%.
- On the Quality and Safety Boards throughout EGA wing we saw that it had been 1068 days without any cases of Methicillin Resistant Staphylococcus Aureus (MRSA) or Clostridium Difficile (C.Diff) Infection. On T6 there had been no cases of MRSA and 82 days since the last case C. Diff.
- Personal Protective Equipment (PPE) was readily available in all of the clinical area we inspected.

Environment and equipment

- Intercom and buzzer systems were in use to gain entry to the labour ward and maternity wards. This meant that staff could identify visitors and ensure that women and their babies were kept safe. On the Antenatal Care Unit (which had been created last year to give ten extra beds and shared intercom and buzzer system with the Birth Centre), midwives told us of their concern regarding interruptions in provision of are to women to answer the door intercom. We escalated the concerns to the Divisional Management team and was assured that the team are aware of the staff concerns and that an audit is being commissioned to capture the number of interruptions on a shift by shift basis.
- We found equipment was clean and fit for purpose. Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that it was safe for use.
- We found that resuscitation equipment was checked daily to ensure equipment and supplies were complete and within date and we saw evidence from the checking that defects were reported and acted upon.
- Maternity staff we spoke with knew the pool cleaning and evacuation procedures.

Medicines

- Medicines including controlled drugs were safely and securely stored. On Labour ward we witnessed that two midwives were not aware of the code to gain access to the drug fridge however on closer inquiry it transpired that new drug fridges had been installed the previous day and the Labour Ward Co-ordinator had not communicated the code to these two individual midwives.
- Records demonstrated that twice daily stock checks of controlled drugs were maintained and that these were correct.
- Temperatures of refrigerators used to store medicines were monitored daily to ensure that medicines were stored correctly and that women and babies were not at risk of the administration of ineffective medicines.
- On the Birth Centre we found a sealed tray containing emergency neonatal resuscitation drugs on the resuscitaire. The Trust informed us that neonatal resuscitation drugs are provided in designated red bags on all resuscitaires on the third floor and on all neonatal resuscitation trolleys.
- On Labour Ward cylinders of Oxygen and Entonox were stored in an area which did not have appropriate signage on the door.

Records

- We saw that patient records were stored securely on the gynaecology and maternity wards.

Maternity records

- We reviewed twelve sets of maternity records. We saw that initial risk assessments were made and revisited in the antenatal period. Record keeping around CTGs was irregular in that. CTG's were all not signed and dated and manual check of the maternal pulse was not recorded.
- We saw examples of multi disciplinary care planning of a woman whose baby would require transfer to Great Ormond Street following birth for correction of a cardiac abnormality.
- On the maternity unit we saw individual maternity records being reviewed as part of the women's care and the personal child health record (red books) were introduced for each new born. Red books are used nationally to track a baby's growth, vaccinations and development.

Maternity and gynaecology

Gynaecology records

- We reviewed four sets of records and saw that appropriate assessment, planning and evaluation was taking place.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and national and local policy. This included a specific safeguarding team for the Women's Health division.
- Staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process.
- We were told by senior staff that all midwives and maternity care assistants had access to level 3 safeguarding children training in line with the intercollegiate document (2015). Updates at level three were provided annually at the mandatory clinical skills update week. Safeguarding training compliance at level three was recorded at 97% compared to the trust target of 90%.
- There was a child and baby abduction policy in place to ensure the safety of babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984.
- Information regarding women with safeguarding concerns was kept in a 'Red Folder'. A flag showed on the maternity service information system for any woman identified with a safeguarding concern to alert staff to the concern.
- Training was ongoing to safeguard people at risk of and treat those affected by female genital mutilation (FGM) for example a monthly 'African Women's' clinic is offered.
- We were told of and saw evidence of systems in place to monitor the disclosure of Domestic Abuse by midwifery staff in line with Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). Senior staff with safeguarding responsibility told us that there was no formal system for safeguarding supervision. The trust did not have a supervision policy, but reference was made to supervision in the trust's safeguarding policy. Formal supervision for named professionals was available through another NHS Foundation Trust (including the safeguarding midwife and community midwives, who were expected to attend quarterly). The trust informed us that 'ad hoc' supervision was also available for any other staff member or teams of staff where individual cases created any concern or anxiety.

Mandatory training

- Trust mandatory training covered subjects including adverse incident reporting, conflict resolution, equality and diversity, fire prevention, infection control, learning disability awareness, load handling, and positive mental health. We saw that 87% of the nurses and midwives had completed mandatory training compared to the trust target of 90%.
- Maternity specific mandatory training and other learning and development were managed by the Education team. We saw that 93.5% of midwifery staff and 86% of medical staff had completed mandatory PROMPT (Practical Obstetric Multi-professional Training) training.
- Specific maternity mandatory training took place over four days and covered subjects including: maternal and neonatal resuscitation, electronic fetal monitoring, care of the deteriorating woman including management of sepsis, perinatal mental health updates and safeguarding.
- Multidisciplinary simulated 'core skills' training was in place for maternity staff to maintain their skills in obstetric emergencies including management of post-partum haemorrhage, breech presentation, shoulder dystocia (difficulty in delivery of the baby's shoulders) and cord prolapse. The training took place off site in the Education Centre's simulated training suite. A simulator mannequin had recently been purchased and a skills drill facility created on Labour Ward to facilitate live skill drills within the clinical area.
- Staff told us that the content of the maternity specific study days were changed annually to reflect incidents that had taken place for example training sessions related to intermittent auscultation of the fetal heart.

Maternity and gynaecology

Assessing and responding to patient risk

- For women using maternity services the booking visit took place before 12 weeks and six days of pregnancy and included a detailed risk assessment. An initial maternity booking and referral form was completed by midwives at the booking visit. Between April and December 2015 80% of women were seen by a midwife by 12 weeks and six days gestation of pregnancy. We saw that on-going risk assessment was documented at subsequent antenatal visits which meant that we were assured that referral to the obstetric team would be made if risk factors were detected.
- All patients, on admission, receive an assessment of VTE and bleeding risk using the clinical risk assessment criteria described in the national tool. Performance is monitored monthly.
- Women that had problems in pregnancy were reviewed on the MAU. From here, they could be admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording foetal growth, counselling women regarding foetal movements and smoking cessation, and monitoring babies at risk during labour. We saw that customised fetal growth charts were in use to help identify babies who were not growing as well as expected. In addition all women were routinely scanned at 36 weeks gestation.
- Women were offered vaccinations against influenza and whooping cough. We saw notices on the maternity unit advising people who may have travelled to South America to seek advice about the Zika virus.
- Maternity staff used the National Early Warning Score (NEWS) for non-pregnant women and the modified early obstetric warning score (MEOWS) to monitor pregnant women in gynaecology; in labour and to detect the ill or deteriorating woman. We saw that there was an extended MEOWS chart used when women required high dependency care. During our visit, we observed that use of the MEOWS identified deteriorating women and that appropriate clinical decisions were made.
- We saw evidence of a guideline for management of sepsis in the obstetric patient which helped staff identify women at risk of sepsis and initiate required treatment.
- Women requiring management of complications were cared for on the Close Observation Bay (COB), a four bed bay on labour ward. Care was provided by a midwife trained in high dependency care. Any woman who needed additional support and care was transferred to the intensive therapy unit (ITU). The COB was also used for recovery after caesarean section.
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organisation's (WHO) Five Steps to Safer Surgery' guidelines. We saw documentary evidence that all the stages were completed correctly and that checklists showed that this was usual practice.
- The senior midwives on duty provided CTG review known as 'fresh eyes'. This was in accordance with NICE Intrapartum Guidelines. It involved a second midwife checking a CTG recording of a baby's heart rate to ensure that is it was within normal parameters. We saw evidence in the maternity notes that we checked (12 sets) that 'fresh eyes' reviews had been completed.
- Formal multi-disciplinary handovers were carried out twice per day on the labour ward attended by medical staff and midwifery staff. We observed the 7.30am handover which was structured and included discussion on all maternity inpatients and overnight deliveries. Care was assessed and planned at this handover and work allocated to the appropriate member of staff.
- There was a Did Not Attend (DNA) policy that the trust adhered to. This meant that staff were aware of women who had missed appointments and could arrange follow up to ensure that women attended for care and safeguarding concerns were raised when they did not do so.

Midwifery staffing

- Birthrate Plus® is a midwifery workforce planning tool which demonstrates required versus actual staffing need to provide services. Birthrate Plus® is recommended by the Department of Health; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority.

It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.

- The trust had completed Birthrate Plus® in November 2015 and currently had a vacancy rate for midwifery staff of 7% and had recently undergone two rounds of recruitment. The current Midwife to Birth Ratio was 1:29.
- Midwives worked a mixture of 8 hours and 12 hour shifts. Labour ward coordinators are responsible for the management of the activity on the ward and require constant oversight of the ward so that decisions can be made regarding care and treatment and flow of patients. We saw that the band 7 labour ward coordinator was not always supernumerary in practice although this was the aim. This meant that there could be an impact on the safety of women in labour as the co-ordinator needed to have an overview of activity at all times in order to manage the ward safely. We were told that this will be addressed through workforce planning, which might include a business case in order to progress.
- The planned and actual staffing levels were displayed at the entrance to each maternity ward. The labour ward required eleven midwives and one maternity support worker (MSW) on each shift. We saw that actual staffing was nine midwives and one maternity support worker on labour ward during our inspection.
- Staffing requirements for the antenatal ward was two midwives on both day and night shift. On the postnatal ward staffing requirements were 4 midwives and 4 maternity support workers on each shift. We saw that required and actual staffing was met on this ward during our inspection.
- Staffing requirements for the MAU and Triage was six midwives.
- We were told and saw documentary evidence that the vacancy rate was 7% and; the sickness rate was 3.8%.
- The maternity unit used agency staff and had its own bank of temporary staff which was made up of permanent staff who undertook extra work to cover shortfalls. Bank midwives undertook the same mandatory training as substantive staff. We saw that on average 12% of shifts were covered by bank staff each month.
- There was a lone worker policy which community midwives adhered to.

Nursing staffing

- We saw a safe staffing board that demonstrated planned staffing met the trust's actual staff ratios for each shift. The Royal College of Nursing (RCN) recommends a nurse to patient ratio of 1:8 (RCN 2012). This meant one registered nurse (RN) for eight patients. The ratio on the unit was 1:5 on days and 1:7 on nights.
- Prior to August 2015, gynaecological patients were not nursed in a specific area. A scoping exercise identified a specific gynaecological ward. This is staffed by nurses who have been gynaecology trained. 50% of nurses in maternity and gynaecology have received this training.
- The ward was supported by Advanced Nurse Practitioners.
- Specialist gynaecology nurses worked in outpatient clinics to provide colposcopy, rapid access, fertility, cancer and vulval services.

Medical staffing

- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations. There was a resident anaesthetic consultant dedicated to obstetrics Monday to Friday 08:00-18:00. Outside of these hours and days there is a 24/7 anaesthetic consultant on call.
- There were 88 hours of obstetric consultant cover per week on the labour ward, as well as consultant presence for all elective Caesarean section lists. At the time of the inspection the consultant staff stayed on the labour ward every day from 8am until 10pm, Monday to Friday and from 8am until 5 pm on Saturdays and Sundays. Out of hours cover was provided by the consultant on call. A second consultant attended labour ward for elective caesarean sections. We were told that the Trust had plans to recruit new consultant obstetrician posts to take the ratio to 96 hours per week.
- The level of consultant cover was 35% which was equivalent to the national average of 35%. The

percentage of registrars 57% which was greater than the national average of 50%. The percentage of middle grade doctors was 7% which was similar to the national average of 8%. There were 1% junior grade doctors which was less than the national average of 7%.

- A consultant anaesthetist provided cover for labour ward between 7.30am and 5pm weekdays. Out of hours cover was provided by the on-call consultant.
- We saw that Deanery senior house officer posts were not fully filled. The trust employed locum staff to meet this shortfall. However, it was difficult to source sufficient staff. Staff told us that there were unfilled shifts at registrar level.
- The gynaecology service was covered by a junior trainee and a registrar. Consultant cover was provided by the daily consultant ward round and consultant on call.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) by consultants and/or middle grade staff.

Major incident awareness and training

- Staff were aware of the procedures for managing major incidents and fire safety incidents.

Are maternity and gynaecology services effective?

Good

Overall we rated the service as good for effective.

Staff had access to and used evidence-based guidelines to support the delivery of effective treatment and care. Care and treatment reflected current evidence-based guidance.

Information about patient care, treatment and outcomes was routinely collected, monitored and used to improve care for example, a review of caesarean section rates.

Women we spoke with felt that their pain and analgesia administration had been well managed. Epidurals were available over a 24-hour period.

Staff were competent in their roles and undertook appraisals and supervision. We saw good examples of multidisciplinary team (MDT) working in the maternity service. Staff worked collaboratively to serve the interests of women across hospital and community settings.

Access to medical support was available seven days a week. Community midwives were on call 24 hours a day to facilitate the home-birth service.

We saw examples of outstanding world class practice, notably the One Stop first trimester Down's syndrome Screening clinic with immediate Fetal Medicine referral, the gynaecology Integrated 'One Stop' Diagnostic and Testing service, and the see and treat service in colposcopy. Surgical management of miscarriage under local anaesthetic in the Early Pregnancy Unit and integrated multi-disciplinary working within the Fetal Medicine Unit were also examples of outstanding practice.

Evidence-based care and treatment (Maternity)

- Policies were based on national guidance produced by NICE and the Royal Colleges. Staff had access to guidance, policies and procedures via the trust intranet.
- We saw that the care of women using the maternity services was in line with Royal College of Obstetricians and Gynaecologist guidelines (including Safer Childbirth: minimum standards for the organisation and delivery of care in labour). These standards set out guidance in respect to the organisation and include safe staffing levels, staff roles and education, training and professional development, and the facilities and equipment to support the service.
- Staff told us and we saw evidence that the inability to achieve 1:1 care in labour is a midwifery 'red flag' event and in such instances the maternity escalation plan was instigated. We did not see an audit of 1:1 care in labour; however, the trust told us that 1:1 care is continuously monitored on the Medway IT system.
- We found from our discussions and from observations that care was being provided in line with the NICE Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy
- The trust offered screening in line with the National Screening Committee (NSC) recommendations. Patients were supported to make decisions around screening

and were provided with the NSC leaflet at booking. We saw documentary evidence to show that the 10 week KPI for haemoglobinopathy screening was 52% and the uptake for Down's screening was 73%.

- Women with high risk results were invited into the FMU for ongoing management and tests such as chorionic villi sampling (CVS).
- We found evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, and care of the new born baby.
- All labouring women were assessed on triage and admitted to the birth centre or labour ward. There was not a default pathway for low risk women to be admitted to the birth centre which meant that they could be cared for in the high risk environment on labour ward. Staff told us that they would like to develop a different approach so that low risk women were not on labour ward.
- We saw RAG (Red, Amber Green) risk rated guidance for the assessment of women in triage. This included anticipation that the majority of non-labouring women be sent home after review.
- The latent phase of labour is the early stage of labour before contractions become regular, longer and stronger. Best practice (NICE, 2014) is that women who are not in established labour have better outcomes if they stay at home. We saw that low risk women had care provided in line with best practice.
- The fetal monitoring guideline was not compatible with NICE (2014) recommendations for categorising fetal heart rate monitoring during labour and the trust was still using the 2007 NICE guidance. The Trust along with the North Central London Maternity and Newborn Network were looking at the feasibility of introducing the International Federation of Gynaecology and Obstetrics (FIGO) consensus guidelines on intrapartum fetal monitoring that were published in October 2015. However to avoid confusion amongst staff a decision had been made to continue with NICE (2007) Guidelines until national clarity was achieved thus clear mitigation was achieved.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 132.
- The caesarean section rate for April to September 2015 was 29.1%, which was higher than the national average of 25%.The trust's trigger on the dashboard was 26%. The trust mitigated against the high rate of caesarean sections by publishing data for elective caesarean section (ELCS) due to maternal request which was just over 2.0% for the same period. Further scrutiny of the demographics revealed that 70% of women were from outside the catchment area of UCLH. We saw evidence of robust pathways for women requesting elective caesarean section which if all avenues of the pathway are exhausted and the woman is still requesting a caesarean then choice is offered as per NICE CG132.
- The senior team told us that the difficulty in reducing the caesarean section rate was poor uptake of vaginal birth after caesarean section (VBAC) and the numbers of women requesting ELSC.
- We asked the management team for the strategy to reduce the caesarean section rate. We asked the management team for the strategy to reduce the caesarean section rate; this was explained and we saw an action plan. The plan included: an improved pathway for external cephalic version for breech presentations; monitoring of ELCS, daily caesarean section case review and reviewing practice and training around CTGs
- We saw that there was a VBAC pathway aimed at reducing the caesarean section rate. A clinic was held by one of the consultant midwives.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect of postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Maternity and gynaecology

Evidence-based care and treatment: Gynaecology

- Minor gynaecological surgery was undertaken on a day case basis. The expectation was that the woman went home on the day of the procedure.
- There was evidence from information reviewed and from discussion with staff that the service adhered to The Abortion Act 1967 and Abortion Regulations 1991. This included the completion of necessary forms; HSA1 and HSA4.
- Surgical and medical terminations were performed up to 20 weeks of pregnancy. Choice was offered in line with RCOG Evidence-based Clinical Guideline Number 7: The Care of Women Requesting Induced Abortion. Women could choose to have early medical abortion (EMA), late medical abortion or surgical treatment under local or general anaesthetic.
- Manual vacuum aspiration (MVA) performed under local anaesthetic was available for the termination of pregnancies up to nine weeks. This procedure was carried out in a weekly clinic on the EPAU.
- Women whose pregnancies were between 10 and 14 weeks were offered surgical with a general anaesthetic treatment as a day case. Women whose pregnancies were between 14 and 20 weeks were admitted to T6 for treatment and Women whose pregnancies were between 16 and 20 weeks were cared for on labour ward.
- Consent was appropriately and correctly obtained in line with Department of Health RSOP 8: consent. Consent was obtained at the assessment visit and again on the day of treatment.
- Patients were offered a choice of medical or surgical treatment for termination of pregnancy. We saw that consent forms were completed appropriately. 56 medical abortions were performed and 47 surgical abortions were performed.
- RCOG Clinical guideline No. 7 advises that information about the prevention of sexually transmitted infections (STI) should be made available. All women under 25 were tested for Chlamydia infection prior to any treatment (Chlamydia is a sexually transmitted bacterial infection). Women with positive test results were referred to sexual health services. Women were also referred to sexual health services for further screening for other STI and treatment.
- We saw documentary evidence that blood was tested at the initial assessment to determine Rhesus factor and Anti-D immunoglobulin administered to women who were found to be rhesus negative.
- We saw documentary evidence that contraceptive options were discussed with women at the initial assessment and a plan was agreed for contraception after the abortion. These included Long Acting Reversible methods (LARC) which are considered to be most effective as suggested by the National Collaborating Clinic for Women's and Children's Health.
- Women undergoing medical abortion were asked to ensure that a pregnancy test was completed after four weeks post procedure to ensure that the procedure had been successful.
- A discharge letter was given to women providing sufficient information to enable other practitioners to manage complications in line with DH RSOP 3: Post procedure.
- Women were advised of an emergency number to call if they experienced complications.
- We asked about the care of people under the age of 16. A safe contact number was provided to younger patients and they were required to bring someone over the age of 18 with them when they attended for treatment. All people under 16 were referred to the safeguarding team. Children under the age of 14 were referred to the paediatricians.
- We saw that there were policies in place for the disposal of fetal remains. Fridges were available on T6 and the EPAU for this purpose. We were told that staff did not always adhere to this policy.

Audit

- The trust provided us with the robust clinical audit plan for 2015/16. This draws upon all national and local maternity service drivers, and is also informed by national and local service development including incidents and complaint action plans.
- Audits were presented and discussed at the Clinical Governance and Audit meeting which were open to all staff. We saw that data was analysed and that recommendations and action plans were made as a result of audits.
- The trust actively participated in national audits including the National Screening Committee Antenatal

and Newborn Screening audit, the National Diabetes in Pregnancy Audit and Mothers and the national report for perinatal mortality for births: Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE). We were not shown the results of these audits.
- Examples of obstetric audit included major obstetric haemorrhage, shoulder dystocia and category one (emergency) caesarean sections.
- Examples of gynaecology audits included colposcopy , antimicrobial use and antral follicle count.
- We saw evidence of an audit in December 2015 of MEOWS which had identified that clinical staff did not always complete the full set of parameters when doing observations. A plan of action had been developed which included a daily snapshot check of MEOWS, and updates in the maternity safety newsletter which we saw evidence of.
- The Morecambe Bay Investigation was established by the Secretary of State for Health in September 2013 following concerns over serious incidents in the maternity department at Furness General Hospital (FGH). The report made 44 recommendations for the trust and wider NHS, aimed at ensuring the failings are properly recognised and acted upon. We saw documentary evidence that the trust had carried out a benchmarking exercise which found that full compliance against the recommendations.

Pain relief
- Women we spoke with in maternity and gynaecology felt that their pain and administration of pain relieving medicines had been well managed.
- On the labour ward we saw a variety of pain relief methods available including Tens machines and Entonox, a ready to use medical gas mixture of 50% nitrous oxide and 50% oxygen that provides short term pain relief. Epidurals were available 24 hour a day.
- Birthing pools were available in both the birth centre and consultant led labour ward so women could use water immersion for pain relief in labour.

Nutrition and hydration
- The Infant Feeding midwife was responsible for the oversight of infant feeding. The trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby.
- The trust had been awarded UNICEF Baby Friendly Initiative stage three, which meant the trust supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- Women told us that they received support to feed their babies. We saw that the initiation of breast feeding rate was 94% which was better than the national average of 75%.
- Babies with tongue tie (a condition where the string of tissue between the baby's tongue and floor of the mouth is too short and affects the baby's ability to latch onto the breast causing feeding problems) were referred to a neonatal clinic where the doctor could divide the tongue tie if required. This meant that women and babies received timely intervention when feeding was complicated by tongue tie.
- Patients told us that food was available outside of set meal times if they did not feel like eating or were unable to eat at set meal times.

Patient outcomes
- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) recommends the use of a maternity dashboard. The Maternity Dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.
- The trust was using a dashboard that had been developed by the North Central London Maternity and Newborn Network. This enabled comparative data to be used across the trust and across the maternity units in North Central London.
- Information on the dashboard from April to November 2015 demonstrated that:
- The caesarean section rate was 29.1%, which was higher than the national average of 25%.
- The elective caesarean section rate was 14.7%, which included 2% that were due to maternal request, compared the national average 10.7%

Maternity and gynaecology

- The emergency caesarean rate was 16% compared to the national average of 14.7%.
- The instrumental delivery rate was 17.6%. The differentiation between Ventouse and forceps delivery was not recorded. The national average for Ventouse delivery is 7% and the national average for forceps delivery is 5.8 %.
- The third or fourth degree tear rate was 4.8% of patients.
- The trust recorded postpartum haemorrhage above 1.5 litres on the dashboard and there were 140 such haemorrhages between April and November 2015 which equated to 3% of patients.
- The trust recorded 15 stillbirths in the twelve months January to December 2015.
- The normal delivery rate for February 2015 was 53.2%, which is below the RCOG recommendation of 60%.
- The homebirth rate was 1.4% which was lower than the national average of 2.3% but when adjusted to the local catchment area was 3.4%.
- We saw documentary evidence that 7.7% of term babies were admitted to the Neonatal Unit from April 2014 to March 2015 and of these 14 babies (with a gestational age of over 35 weeks and weighing more than 1800grammes) admission was due to avoidable events.
- The normal delivery, home birth and unexpected term admissions to the neonatal unit rates were not recorded on the dashboard.
- The latest CQC Intelligent Monitoring report (May 2015) found no maternity outliers for this trust.

Competent staff (Maternity)

- An induction period of two weeks orientation was offered to newly appointed staff.
- All newly qualified midwives undertook a twelve month preceptorship period prior to obtaining a band 6 position. This meant that they were competent in cannulation and perineal suturing and had gained experience in all areas of the maternity service.
- Appraisal rates for staff were provided for us and these demonstrated that 68% of midwives had been appraised. The consultant appraisal rate was 100%.
- Staff told us that they were 'impressed' with the professional development opportunities available to them. They were encouraged to apply and attend study course outside of mandatory training.
- Staff described the duty of candour study day that they were encouraged to attend The Matrons of each department also meet weekly specifically to address and ensure timely duty of candour.
- We were told that 50% midwives were qualified in newborn and infant physical examination (NIPE).
- Royal College of Anaesthetists (2011) recommended that practitioners, who undertake recovery duties post-surgery, must meet specific criteria in achieving their competencies. We saw evidence that recovery training was included within the mandatory training for midwives
- Midwives rotated throughout the service which meant that they were competent to work in all areas in times of escalation.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The NMC sets the rules and standards for the statutory supervision of midwives. Supervisors of Midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:13 which confirmed that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.
- We spoke with twelve patients on the postnatal ward who all reported they felt cared for by skilled staff and felt safe in their care.

Competent staff (Gynaecology)

- We were told that T6 staffing complement was composed of 50:50 ratios of nurses with gynaecology and surgical experience. The ward manager had recently ran a training programme for all nurses on the ward on pain management that included the management of epidural and Patient Controlled Analgesia (PCA's).

- Junior doctors reported very positive feedback on training and the support they received from the obstetrics and gynaecology consultant team.

Multidisciplinary working

- A multidisciplinary handover took place twice a day on the labour ward. The handover used an SBAR (Situation-Background-Assessment-Recommendation) handover sheet and included an overview of all maternity patients.We saw that the BIG 4 Safety Huddle was discussed which was related to sending of placentas for histology, application of fetal scalp electrode, checking of blood results, record keeping and checking of emergency equipment.
- During handover, we saw that the review of the women on labour ward included a review of the cardiotocograph (CTG) utilising the K2 Guardian fetal monitoring system.
- Communication with community maternity teams was efficient. In the community we were told of effective multidisciplinary team work between community midwives, health visitors, GPs and social services.
- The ward informed community midwives and GPs when a woman had suffered a pregnancy loss. They informed the obstetric office so that ongoing appointments could be cancelled.
- We were told of multidisciplinary links with external trusts. For example, the trust was a member of the North Central London Maternity and Newborn Clinical Network which enabled the trust to develop shared polices to ensure consistency of quality across the region.

Seven-day services

- Access to medical support was available seven days a week. The early pregnancy service was available seven days a week but with reduced opening times over the weekend.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

- Trust intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides, policies and procedures to assist in their specific role.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that the procedure of consent was reviewed prior to surgical procedures which were good practice.
- There was 95% compliance with Mental Capacity Act 2005 training and we saw evidence in each clinical area of a toolkit specifically for staff to refer to if applications to the Act were required
- We spoke with staffs that were able to articulate how the Mental Capacity Act and Deprivation of Liberty Safeguards were applied in practice.

Are maternity and gynaecology services caring?

Good

Overall, we rated the service as good for caring.

Feedback from patients and those close to them was positive. Overwhelmingly we received feedback that care was excellent and compassionate. Women reported being treated with dignity, respect and kindness during all interactions and patient-staff relationships were very positive.

Patients were involved and encouraged to be partners in their care and were supported in making decisions. Both maternity and gynaecological patients told us that they felt well informed, understood their care and treatment and were able to ask staff if they were not sure about something.

Midwifery staff responded compassionately when patients needed help and supported them and their babies to meet their personal needs. Staff helped patients and those close to them to cope emotionally with their care and treatment.

Patient's spoke highly of the nursing staff on the gynaecology ward and told us care had been 'really good'.

Compassionate care

- Maternity services were added to the Friends and Family Test (FFT) in October 2013. From December 2014 to November 2015 there was mixed performance of scores against the national average. Scores were similar to the England average in proportion of women who would

recommend the antenatal and postnatal services. Scores were below the England average for birth services and above for the proportion of women recommending postnatal community provision:

- 92% of women would recommend the antenatal service.
- 91% of women would recommend the labour ward.
- 93% of women would recommend the postnatal service.
- 98% of women would recommend the postnatal community service.

- The CQC maternity survey of December 2015 surveyed women who gave birth in February 2015. A total of 23 women, a response rate of 41%, returned a completed questionnaire. It showed that most outcomes were similar to the national average. The trust scored better than other trusts' in two areas: women were given a choice about where antenatal check-ups would take place and decisions about how women wanted to feed their babies respected by midwives

- The trust had significantly worse scores compared to most other NHS trusts in England for four areas. At the start of labour women felt that they were not given appropriate advice and support when they contacted a midwife or the hospital. In labour women were not able to move around and choose the position that made them feel comfortable. Women felt that the length of stay following the birth was inappropriate. Women felt that they were not always treated with kindness and understanding following the birth. As a result, the trust has established a Maternity Service Liaison Committee (MSLC) chaired by a service user. The Trust has procured the national 'Whose shoes' programme which facilitates participation from staff and maternity service users.

- All women we spoke with were positive about the treatment by clinical staff and the standard of care they had received. Women told us that they had a named midwife. They felt well supported and their care was delivered in a professional way. Comments included "brilliant birth experience," "staff sensitive, happy with every stage of the procedure" and "had every confidence in the staff". We saw that thank you cards were displayed in ward areas; an indication of appreciation from women and those close to them. In addition a large proportion of the women which we spoke to chose to give birth at EGA even though other maternity services were closer to their homes.

- We observed positive interactions from all staff from ward domestic to consultant with women and their partners. Staff were seen to be calm and compassionate. Altering their communication style depending on the situation. We heard staff providing advice and encouragement, as well as dealing with urgent situations with calmness and efficiency.

- Understanding and involvement of patients and those close to themWomen told us that they felt well informed and able to ask staff if they were not sure about something. One patient told us that she felt the staff took her pregnancy complications seriously and involved her in all reviews of her care.

- Gynaecology patients told us that they felt informed and that "things were explained step by step".

- Partners of maternity patients described feeling involved in the care provided. One father told us that he was involved in all decisions. He cut the cord at the birth and "felt part of the team".

Emotional support

- Bereavement support was offered by a specialist midwife.
- Memory boxes were provided to parents who had suffered a pregnancy loss.
- Chaplaincy support was available.
- Counselling for termination of pregnancy was provided at the trust.

Are maternity and gynaecology services responsive?

Good

Overall we rated the service as good for responsive.

Patients' individual needs and preferences were considered when planning and delivering services.

Maternity and gynaecology

Whilst a room on labour ward had been dedicated as a bereavement room capacity issues within the service meant that this room was frequently used as a labour room which meant that a woman and her partner could be cared for on the main labour ward.

The maternity service was flexible and provided choice and continuity of care.

The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support people with particular needs.

Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

Service planning and delivery to meet the needs of local people

- Women could access the maternity services via their GP or by contacting the midwives in the integrated antenatal clinic directly.
- Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.

Access and flow

Maternity

- The maternity unit had not closed between January 2014 and December 2015.
- Women could access the maternity service via their GP or by direct referral. NICE guidance recommends that women are seen by 10 weeks of pregnancy so that the early screening for Downs Syndrome, which must be completed by the 13 weeks and six days of pregnancy, can be arranged in a timely manner. We saw that between 90-98% of women were seen by a midwife by 12 weeks and six days of pregnancy between April and November 2015. The first trimester Downs Screening is run as a 'one stop clinic' in the Ultrasound department within the Integrated Antenatal Clinic. A Biochemistry labarotory is situated within the site. Ultrasound scan and maternal serum biochemistry are performed almost simultaneously with the result being reported to the woman face to face the same day. Where the result is high risk (>1:150) local guidelines state that referral to the Fetal Medicine Unit must be made on the same day. The team considered this was an example of outstanding practice.
- We were told about and saw written documentation which confirmed women were supported to make a choice about the place of birth. We saw that women were risk assessed at booking and that low risk women defaulted to a low risk pathway. We were told that discussion had taken place to look at the location of the triage area and plans were being made to increase the flow through the birth centre by making the birth unit the default destination for low risk women to labour.
- The FMU were able to provide rapid access and are able to see urgent referrals within 48 hours.
- The FMAU and triage provided an assessment service to women over 14 weeks of pregnancy as a 24 hour service on an appointment basis. Women could be referred to the FMAU by community midwives, GPs, or they could self-refer. Day care was available for women with concerns such as hyperemesis (excessive sickness in pregnancy) and reduced fetal movements. Pre-operative assessment was also managed on the FMAU. The FMAU was run by six midwives and a support worker. Medical cover was provided by obstetricians from the on call team and staff told us that delay in medical review impacted on timely management and treatment for patients.
- There was a designated triage area within the FMAU where women with urgent complaints could be reviewed and assessed. Women were provided with the telephone number for triage and a midwife was allocated to work the triage telephone referral system on a daily basis.
- A birth centre with seven rooms was located on the floor above labour ward. Two of the rooms had a pool for women to use for pain relief in labour and for birth. This area was functioning as a birth centre and had separate guidelines. We were told of discussions to make the birth centre the default setting for low risk women to give birth in the centre rather than labour ward.
- There were eight elective caesarean section lists per week and there were typically six operations on each list.

- We were told that there had been delays in discharging women from the postnatal ward. As a result, work had been done over the last four months and a multidisciplinary approach had been adopted to specifically look at improving flow whilst still managing women's expectations of postnatal care. An example of the improvements that had been made was the establishment of a 'baby clinic'. The 'baby clinic' now operated on a daily basis and consisted of a midwife trained in Newborn Initial Examination (NIPE) working alongside a paediatrician to avoid delays. Other examples of how access and flow on the postnatal ward had been improved included postnatal discharge information been delivered to the woman on admission to the ward, and any drugs to take home being ordered prior to transfer from the labour ward. A picker style survey of 15 women had been undertaken specifically to look at women's experience of the initiative which had seen a marked improvement overall.
- We noted that quarterly bed occupancy was 66.8% between June and September 2015. This was similar the England average of between 62%. This indicated that women were having similar length of stays in hospital in comparison to the other trusts.

Gynaecology

- The gynaecology diagnostic and outpatient treatment unit included the Emergency Pregnancy Unit, General Gynaecology Clinic and a diagnostic scanning service for GP's to access. In addition outpatient procedures such as Hysteroscopy, Colposcopy and Evacuation of Retained Products of Conception (ERPC's) are also performed in the outpatient procedure room.
- Gynaecology patients were cared for on T6.
- An early pregnancy assessment unit (EPAU) offered appointments between 9am and 4.30pm weekdays and 9am to 12.30pm on Saturdays and Sundays. Referrals for investigation and treatment into bleeding in early pregnancy were accepted from midwives, GPs and the emergency department. There was access to scans and medical opinion was accessible from the on call registrar. The system ran on a first come first served basis with priority given to women who are seriously unwell. Both staff and patients told us that the clinic was very busy which resulted in long waits
- The general gynaecology service offered an initial consultation and diagnostic test in one visit. Ultrasound scan could be offered simultaneously resulting in women having a treatment plan drawn up for them immediately. The clinic sees over 1200 women per year with approximately 11% of women requiring a follow up appointment. The team considered this was an area of outstanding practice.
- The colposcopy service was both consultant and nurse led. The service offered the full range of colposcopy services depending on the reason for referral. These were: referral / new appointment to confirm a diagnosis and evaluate if treatment needed; 'See and treat' appointment which was a one stop clinic for initial examination and treatment; nurse led smear clinic for women who are at a low risk of developing cervical cancer but who cannot be discharged to their GP and post treatment clinics for follow up following treatment.
- The gynaecology service met the incomplete pathway RTT target, the 31 day cancer target , and the 2 week cancer wait target in each of the four months before the visit. It did not meet the 62 day cancer target in December, January and February: all breaches were due to late external referrals. All internal patients were compliant with the 62 day target.

Meeting people's individual needs

- We saw that the gynaecology diagnostic and outpatient treatment unit had limited waiting area. We were told that the inadequacy of the space had been escalated to the divisional management team but the constraints of the building precluded improvements.
- The consultant midwife held a Birth Options Clinic for women requesting home birth when risk factors were present. A birth plan was made in discussion with the woman to support labour ward staff.
- The birth centre birthing rooms offered specialist equipment such as beans bags and birthing balls to promote the comfort of women in labour. Two birth pools were located in rooms for women who wished to use water immersion for pain relief in labour. In addition the labour ward had a pool with telemetry equipment available to ensure that water immersion was available for high risk women to use.

Maternity and gynaecology

- The MFAU ran a daily prolonged pregnancy clinic. The clinic saw all women at 41 weeks gestation. An ultrasound scan was performed to elicit placental well being and a 'stretch and sweep' of the cervix was offered to women.
- The trust ran a joint antenatal and endocrine clinic to support women throughout pregnancy. Specialist midwives for diabetes, screening and fetal medicine, safeguarding who, having successfully completed additional training, gave advice and support to women and midwives.
- There was a specialist midwifery team for vulnerable women. The Perinatal Mental Health Service offered triage, psychiatric and psychological assessment, short term intervention and onward referral for women booked for antenatal and intrapartum care The service receives over 450 referrals a year with over 80% of women being seen in the outpatient clinic.
- The trust ran a weekly Female Genital Mutilation (FGM) clinic to provide care and support for women experiencing problems as a result of FGM. The service was staffed by an exclusively female team to ensure that the complex and sensitive nature of issues relating to FGM are understood
- We saw that there were effective and comprehensive processes for screening for fetal abnormality. In the FMU we observed a team of fetal medicine doctors and midwives who were supported by health care assistants and administrative staff resulting in a seamless service for women. The FMU offered screening for chromosomal defects and invasive prenatal diagnosis for chromosomal abnormalities and genetic syndromes. In addition investigation therapy and management of suspected or known fetal abnormality was offered. The service offered monitoring and treatment of women with rhesus alloimmunisation and alloimmune thrombocytopenia. The FMU is the regional haemoglobinopathy genetics centre for the diagnosis of haemoglobin disorders. The service had multi disciplinary clinics in cardiology, dysmorphology, genetics, neurology, surgery and urology. The clinic also provided services for the management of multiple pregnancies and their complications, pregnancies with placental insufficiency and fetal growth restriction and a clinic for the prediction and prevention of pre term birth. The consultant team comprises of individuals who are internationally recognised as leaders in the field of fetal medicine.
- Women identified with a high risk of fetal abnormality, such as Downs's syndrome, were invited into the FMU for on-going treatment as a one stop service.
- Partners could visit between 8am and 9pm. Other people could visit at fixed times. This enabled new parents to spend private time with their babies.
- We saw a variety of patient information leaflets available for both maternity and gynaecology patients.
- Information leaflets were available for women suffering pregnancy loss outlining the choice of expectant (awaiting events) or surgical management.
- We saw that there was an interpreter service available by telephone but there was a wide range of languages spoken by staff who were often utilised to interpret.
- Privacy and dignity was enabled by the use of privacy screens around beds and on the entrance to rooms on labour ward.
- Telemetry CTG machine were available which meant that women were able to be mobile in labour.
- A bereavement midwife provided care and support to women who suffered pregnancy loss from 16 weeks of pregnancy. A cold cot was available which meant that babies could stay longer with parents. Memory boxes were made up for parents who suffered pregnancy loss.
- There was no dedicated bereavement room and families were cared for in a room on the labour ward. This room was in use by a patient who required isolation at the time of our visit. We asked where bereaved women would be cared for if the room was not available and we were told that they would be cared for on labour ward. Staff expressed dissatisfaction with this arrangement and told us that alternative space off the labour ward was being investigated.
- The Perinatal Loss Psychological Service offered psychotherapeutic intervention for women receiving antenatal and postnatal care, their partners and their children in the event of perinatal loss from 14 weeks gestation until birth.

- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, there was on-site NNU.
- Supervisors of Midwives (SoMs) were available to help midwives provide safe care of the mother, baby and her family. SoMs are experienced midwives with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met women's needs.
- The Supervisors of Midwives provided a 'Listening Service'.
- Gynaecology patients told us that call bells were answered promptly and that they 'wanted for nothing'.

Learning from complaints and concerns

- A complaints manager was responsible for complaints which were handled in line with trust policy. If a woman or relative wanted to make informal complaints, they would be directed to the midwife or nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns. PALS used a closure form for informal complaints so that themes could be identified. Patients would be advised to make a formal complaint if their concerns were not resolved.
- We saw a trust information leaflet for patients and those close to them informing them of how to raise concerns or make complaints. Complaints were reviewed weekly and distributed to responsible officers for investigation and response within 25 days. A quarterly report was submitted to the Divisional Board.
- Information from the trust indicated that there had been 31 maternity and 14 gynaecology formal complaints made between April and December 2015.
- We saw evidence that Duty of Candour was observed.
- We discussed learning from complaints with the management team who told us that care issues and staff attitude were common themes.

Are maternity and gynaecology services well-led?

Good

Overall we rated the service as good for well-led.

There was a statement of vision and strategy and staff we spoke with demonstrated an awareness or understanding of it.

We observed that vital roles such as the labour ward coordinator, even though planned to be supernumerary, sometimes proved not to be.

There were good clinical multidisciplinary working relationships. Leaders were described as visible and approachable.

It was reported to us by a number of members of staff that there were individuals amongst the work force who exhibited challenging behaviour at times. We saw evidence that the Divisional Management team were aware of these issues and implement strategies to work with the individuals involved to modify these traits.

Vision and strategy for this service

- We saw that the Women's Health Division had a short term and long term vision and strategy. This was underpinned by detailed, realistic objectives and plans and staff could articulate the content. A key component of the strategy was maternity expansion plan. Stage one of the plan was the creation of the ten additional antenatal (ANCU) to facilitate induction of labour away from the labour ward and provide a sensitive environment for women with complications of pregnancy. Stage one also included the dedicated inpatient facility for gynaecology patients. The Divisional team told us of their continued work towards a full business case which will provide 2 additional floors for clinical activity within the EGA wing to enable maternity and neonatal services meet demand for both local and tertiary level services.

Governance, risk management and quality measurement

- There was a well defined governance and risk management structure. The maternity risk strategy set out clear guidance for the reporting and monitoring of risk. It detailed the roles and responsibilities of staff at

all levels to ensure that poor quality care was reported and improved. The patient safety team led with responsibility for patient safety, risk, compliance, audit guidelines and complaints.

- The fortnightly multidisciplinary Perinatal Meeting reviewed adverse events in order to identify the causes so that steps could be taken to prevent recurrence.
- Staff told us that they recieved feedback in various ways including at weekly meetings, 'Big 4' safety huddle and a quality and risk newsletter called Maternity Safety.. If they submitted a Datix form, staff recieved personal feedback on the incident reported.Performance issues were taken up with the individual staff member.
- We reviewed the Obstetrics and Gynaecology Governance.The maternity and gynaecology risk register was reviewed monthly at the Risk Management meeting. We saw that the risk register for October to December 2015 contained risks related to maternity and risks related to gynaecology. We saw that risks were RAG rated for example the number one risk for the disvision was that the breast service only had the use of one mammagraph which was rated as red. that progress was noted, that the risk register was discussed at the monthly Women's Health Umbrella Governance Group meeting and reported on a quarterly basis to the Trust Quality and Safety Board.
- The trust used the North Central London Maternity and Newborn maternity dashboard. Quality data was recorded monthly and reviewed at the Women's Health Umbrella Governance Group to identify trends and to aid forward planning. Any outliers (services lying outside the expected range of performance) were reviewed and timely action taken for example the review of all term babies admitted to the NNU.
- Guidelines were kept under review by the Patient Safety team. We saw clear processes for guideline review and discussion at at the Women's Heallth Guidlines group and ratified at the Women's Health Umbrella Governance Group meeting.
- A Labour Ward Forum and Maternity Services Forum met monthly to identify areas of good practice and new evidence based practice. In addition the Maternity Services Liaison Committee (MSLC) met quarterly with minutes and representatives feeding into the wider North Central London MSLC.

Leadership of service

- The service was led by the Clinical Director (CD), Divisional Manager (DM), Head of Midwifery (HOM) and the General Manager (GM).
- Midwifery staff spoke positively about matrons at departmental level and their support in general. We saw good examples of leadership and teamwork at ward level.
- Staff said that senior managers were visible, approachable and supportive.
- Midwifery staff told us that the Head of Midwifery had been in post since January 2016 and commented that already they felt that they were being listened to and that she was very approachable. We found the consultant body to be cohesive and proactive in decision making with innovative approaches to areas such as sub-specialisms and job planning.
- The clinical director (CD) reported a good working relationship with the Head of Midwifery (HOM), the business manager and the medical director. The CD could also go directly to the chief executive officer CEO and felt able to access him as necessary.
- We saw that the Head of Midwifery had direct access to the trust board. This meant that the board could be readily cited on issues relating to maternity.
- Members of the trust board were visible. There was a nominated non-executive director with the responsibility of maternity services.

Culture within the service

- Midwifery and nursing staff all had a strong commitment to their jobs and displayed loyalty to senior staff.
- Staff described a very supportive team culture and told us that there was a 'real sense of team work within the maternity services'. An open, transparent culture was evident where the emphasis was on the quality of care delivered to women. The service encouraged a 'no blame' culture where staff could report when errors or omissions of care had occurred.
- We observed strong team working with medical staff and midwives working cooperatively and with respect

for each others roles. All staff spoke positively and were proud of the quality of care they delivered. A number of midwives and junior staff commented to us that it was a "fantastic" unit to work in.

- From our observations and discussion with staff we saw a strong commitment to meeting the needs and experiences of people using the service.
- We saw that monthly 'Speak Up' sessions were held for directorate staff where staff could attend and raise concerns. These were initiated in response to complaints of bullying and harassment and staff told us that there had been a change in culture.

Public and staff engagement

- The local Maternity Service Liaison Committee (MSLC) focus groups were organised and and chaired by a service user with involvement of the management and team of supervisors of midwives.
- We saw examples of individual services auditing user satisfaction for example the FMU performed a user satisfaction survey on a monthly basis. The results are utilised to drive change. An issue raised within one of the surveys related to waiting times within the department and as a consequence waiting times with the area were displayed.
- The service had developed a virtual tour of the unit and the web site also included useful information for all users of the service.
- The Women's health Division scored 3.79 in the 2015 National Staff Survey for overall staff engagement. This was the same as the average national score for acute trusts.
- We spoke with staff and in all areas staff were very engaged and felt involved in service development.

Innovation, improvement and sustainability

- All staff spoke passionately about the services they offered and the creative ways they worked to ensure they met the needs of women using these services. They explained how their systems and processes were always in line with latest research and guidance. We saw some area of exemplary practice this included the full implementation of the Saving Babies Lives care bundle, the service was already realising a reduction in the number of stillbirths.

Services for children and young people

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

Information about the service

The University College London Hospital (UCLH) provides comprehensive paediatric services for children and young people (CYP) up to the age of 18 years, from the local populations of the London Boroughs of Camden, Islington, Barnet, Haringey and Westminster as well as patients from further afield. Services include a paediatric emergency department, day care unit, in-patient care, surgery, end of life care and general and specialist outpatient clinical service such as asthma, allergy and epilepsy, dermatology, diabetes, endocrinology, rheumatology, dentistry, ophthalmology, ENT services, urology and neonatal unit.

Services for children and young people (CYP) are located in and around the main UCLH hospital site. The department had two in-patient wards for children aged 12 years and under on the eleventh floor of the hospital's tower block (T11S and T11N) and two in-patient wards for young people aged over 12 years and over on the twelfth floor (T12S and T12N). On each floor, the wards are divided into north and south. North wards on each floor provide cancer treatment. The south wards provide more general care and treatment including day surgery and had 15 beds on T11S and 21 beds on T12S.

The CYP service has schoolroom facilities, one for younger children and other for teenagers. A playroom was available on the eleventh floor and an activities room is located on the twelfth floor of the main tower. Teachers, play specialists and activity co-ordinators also work at CYP bedsides when this was more appropriate.

There is an outpatients department on lower ground floor of Elizabeth Garrett Anderson (EGA) Wing, which provides CYP services from 8 am to 8 pm with approximately 5000 appointments per year.

The neonatal unit is located at EGA Wing and comprises of 21 neonatal intensive/ high dependency care cots and 11 special care cots. The neonatal team also provide a transitional care service allowing more mature babies to remain with their mothers if special care is required after birth. There are also two 'rooming-in' rooms available for parents and neonates who require additional support before going home

Information regarding paediatric emergency department is covered under the urgent and emergency section of the report.

Children and young people can access services through their GP, health visitor, midwife or accident and emergency. The trust provides a consultant–led service and works closely with paediatric sub-specialists from hospitals throughout London.

During our inspection, we inspected the general paediatric services, in the outpatient department, T11S and T12S wards and the neonatal unit. We spoke with 80 members of staff, 19 children, and their parents. We examined 15 sets of medical notes for patients treated in the department. We also carried out an unannounced inspection of the department on 23rd March 2016.

Services for children and young people

Summary of findings

We rated the children's and young people (CYP) service at UCLH as good. This was because.

The service had a robust process for ensuring incidents were reported and investigated. All staff were aware of their responsibilities to report and lessons were learnt where incidents had taken place.

Care and treatment reflected current evidence-based guidelines, standards and best practice. The services participated in a number of national and local audits to measure their effectiveness and to drive improvements. Performance against the national neonatal audit programme and the national diabetes audit was better than the national average and there was evidence of local action plans to address any issues identified.

Patient risks were appropriately identified and acted upon with clear systems to manage a deteriorating child or baby. Pain was being effectively managed and regularly monitored. Nutrition and hydration was being monitored and dietitian input was available when needed.

Children were cared for in a caring and compassionate manner. Their privacy and dignity was maintained throughout their hospital stay. Staff ensured that children and their families were informed about their care and were fully involved in any treatment decisions. Consent to care and treatment was obtained in line with legislation and guidance. Fully trained and registered children's nurses and neonatal nurses throughout the service provided care for children and neonates.

Parents were supported to have an active role in the care of their child. They were encouraged to ask questions and learn how to support their child or baby prior to discharge. The needs of individuals were considered and largely met and emotional support was available to patients and their families across the service.

The service had a clear vision and strategy which linked into the overall trust strategy. There was an open and transparent culture with motivated and compassionate staff. They were well informed and said they could raise concerns and were supported by senior staff. There was clear leadership visibility within the department and all staff were clear of their role and responsibilities.

There were clear governance arrangements and we saw evidence of their meetings. Staff were proud to work for the trust and it was clear from speaking to parents that they were satisfied with care delivery. There was evidence of continuous improvement and innovation.

We rated safety in services for children and young people to be good because:

- The service had a robust process for ensuring that clinical incidents were reported and investigated. All staff were aware of their responsibilities to report and lessons were learnt where incidents had taken place.
- Staff understood their roles and responsibilities for safeguarding children and had systems for reporting.
- Clinical areas throughout the hospitals were visibly clean and regular hygiene checks took place. Patient risks were appropriately identified and acted upon with clear systems to manage a deteriorating child or baby.

We rated effective for services for children and young people to be good because:

- Care and treatment reflected current evidence-based guidelines, standards and best practice. The service participated in a number of national and local audits to measure their effectiveness and to drive improvements. Performance against the national neonatal audit programme and the national diabetes audit was better than the national average and there was evidence of local action plans to address any issues identified.
- Pain was being effectively managed and regularly monitored. Nutrition and hydration was effective and was being monitored with dietician input when needed. .
- Consent to care and treatment was obtained in line with legislation and guidance. Staff could demonstrate a good understanding of Gillick competence. Staff involved parents and children in decisions about care and treatment.

Services for children and young people

We rated caring in services for children and young people to be good because:

- Children were cared for in a caring and compassionate manner. Their privacy and dignity was maintained throughout their hospital stay. Staff ensured that children and their families were informed about their care and were fully involved in any treatment decisions.
- Parents were supported to have an active role in the care of their child. They were encouraged to ask questions and learn how to support their child or baby prior to discharge. Emotional support was available to patients and their families across the service.

We rated responsive in services for children and young people to be good because:

- Services were designed appropriately to meet the needs of children of different ages.
- Admission and discharges from each service were managed well, with the help of daily capacity and bed meetings within each department. There were some issues with capacity in the neonatal unit. The needs of individuals were considered and largely met by the service.

We rated well-led in services for children and young people as good because:

- The department had a clear vision and strategy, which linked into the overall trust strategy. There was an open and transparent culture with motivated and compassionate staff who were well informed and felt they could raise concerns and were supported by senior staff and were proud to work for the trust
- There was accessible and visible leadership within the department and all staff were clear of their role and responsibilities.
- There were clear and effective governance arrangements and evidence of continues improvement and innovation.

Are services for children and young people safe?

Good

We rated the children's service at UCLH as good for safe. This was because.

The service had a robust process for ensuring that clinical incidents were reported and investigated. All staff were aware of their responsibilities to report and lessons were learnt where incidents had taken place.

Staff understood their roles and responsibilities for safeguarding children and had systems for reporting.

Clinical areas throughout the hospitals were visibly clean and regular hygiene checks took place. Patient risks were appropriately identified and acted upon with clear systems to manage a deteriorating child or baby.

Incidents

- There were 467 reported incidents in the CYP service during January 2015 to December 2015. 85% of these incidents resulted in no harm to the patient. The top three categories of incidents reported were medication errors, delay in care and general treatment. The neonatal unit (NNU) reported 303 incidents, 68% of these resulted in no harm. The top three categories of incidents reported were medication errors, general treatment and treatment related to maternity issues.
- There were no Never Events reported within paediatric and NNU department. 'Never events' are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event.
- The children's department reported three serious incidents (SI) between October 2014 and January 2016. All three of these incidents involved patients with mental health problems. We looked at the investigations reports of incidents, which included

detailed chronology of events, investigation and root cause analysis. There were recommendations for immediate and future action and arrangements for sharing these recommendations, learning and actions locally and across the trust.

- The Neonatal unit reported 12 serious incidents during April 2015 and March 2016, including one neonatal death and 11 SIs related to maternity, which included eight unexpected admissions to neonatal intensive care unit (NICU). The NNU Women's Health Clinical Incident Review Group(CIRG) reviewed all serious incident cases.
- Lessons learned from incidents were shared across teams via safety bulletin, emails and during safety huddles. We saw evidence of incidents discussed at the monthly paediatric governance meetings and divisional performance meetings. Matron told us changes introduced due to one serious incident, included a new ligature policy being developed and staff given enhanced conflict resolution training. In addition an escalation guide was developed and environmental risk assessment was conducted to ensure the ward was safer for mental health patients.
- Staff said they were encouraged to report incidents and received direct feedback from their line manager and clinical leads in teaching sessions. Staff were aware of the incident reporting procedures and knew how to raise concerns. Junior doctors and nursing staff showed us how they reported incidents on an electronic incident reporting system. .
- We saw minutes of the monthly "umbrella governance meeting" where incidents were discussed. There was also a separate junior-senior meeting, to bring junior and senior doctors and managers together to share learning, solve clinical medical issues including rotas, safety issues and application of guidelines as well as opportunity for juniors to discuss any concerns, recent minutes evidenced discussions about incidents involving errors with insulin prescribing. Management of patients with diabetes out-of-hours was shared with the junior doctors and how to seek advice from endocrine on call consultant via switchboard. We saw minutes of monthly neonatal unit (NNU) clinical governance group meetings where all incidents forms were monitored and discussed.
- The trust performed “about the same” as other trusts for all questions relevant to the safe domain in the Children’s Survey 2014. The questions covered the following areas: ward cleanliness, availability of appropriate equipment and safety on the ward.
- Consultants and junior doctors told us, there were monthly multidisciplinary mortality and morbidity meetings. We saw evidence of cases that were presented at these meetings, which included in depth discussions. However, one nurse told us that at times it was difficult to attend those due to work pressure.

Duty of Candour

- All staff were fully aware of the duty of candour and were able to give examples of how they applied this requirement in practice. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff told us that they receive training on duty of candour at induction. Some junior staff did not always understand the terminology. However, the process they described in communicating with patients and their relatives reflected openness and transparency. Duty of candour training was one of the indicators reported in monthly divisional performance reports and showed 75% compliance with duty of candour level 1 (apology and explanation to patient) and 25% compliance with level 2 (written response) training in December 2015. Staff showed us the “duty of candour sticker” they used in patients notes where appropriate.

Safety thermometer

- The NHS safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins). We found that the NHS safety thermometer information was available on all children’s wards we inspected.
- We saw evidence that safety thermometer data was used to improve the quality of care. For example, the numbers of days since last infections and falls was clearly displayed in each area. We noted that the patient safety thermometer data was discussed at the handover and safety huddles.

- There were no pressure ulcers, falls or catheter related urinary tract infections reported to safety thermometer between September 2014 and September 2015.

Cleanliness, infection control and hygiene

- The trust followed their policies and procedures for hand hygiene and infection prevention and control and audited hand hygiene on a monthly basis. Between June 2015 and November 2015, children services compliance levels varied between 91 to 100%. In neonatal unit (NNU) the hand hygiene results varied between 86% to 100% during September 2015 and February 2016.
- There were dispensers with hand sanitising gel situated in appropriate places around the departments including the main reception. The main entrance doors to the wards had in built hand gel dispensers on the handles to encourage compliance with hand hygiene.
- During our visits, we observed staff consistently complying with hand hygiene practice. . We observed excellent infection control practice in the NNU, where staff advised everyone to wash their hands before entering the department. There were clear bags available at the NNU reception and we observed staff and parents using these for personal items and handbags if they wanted to take those into the department.
- There was a dedicated infection control link nurse, which provided infection control advice and education to staff, visitors and patients. Infection prevention and control posters were prominently displayed in wards and in the NNU, including hand hygiene instructions and advice on how to prevent infections.
- Adequate supplies of personal protective equipment (PPE) including gloves and aprons, were available and we saw staff using these appropriately. We noted that staff adhered to the "bare below the elbows" policy in the clinical areas.
- All of the equipment we examined such as vital sign monitors, hoist, weighing scales, records trollies and toilet rising seats were visibly clean. We observed green 'I am clean' labels were in use to indicate when equipment was cleaned. We observed staff cleaning equipment with sterile wipes after use and beds being cleaned. However, during our unannounced inspection we noticed that some equipment had green stickers with old dates on them, for example, baby weighing scale, doctors notes trolley and mobile laptops.
- Sharps bins throughout children's services had the date recorded of when they were assembled. We also inspected the linen storage areas and noted that there was sufficient clean linen available.
- The trust had two MRSA(Methicillin-resistance Staphylococcus aureus) cases between January 2015 to November 2015. The trust recorded 69 cases of C.difficile during January 2015 to November 2015, the target for hospital-acquired C.difficile for 2015-2016 was 97 cases. We saw these cases were discussed at the monthly divisional performance meeting and information was shared with staff in safety huddles and displayed on quality and safety boards throughout the wards.
- Children's and young people's services had their own dedicated cleaners. We were told that the domestic supervisors were very efficient in guiding the cleaning staff. There was guidance available to help clean patient equipment. We observed domestic staff cleaning the department throughout the day in a methodical and unobtrusive way. We spoke to two cleaning staff, who showed good understanding of separating different types of waste and the use of color-coding to dispose off waste. We checked the area where disposed waste was kept. This was locked in line with policy. Waste segregation and storage was in line with Department of Health 2011 Safe Management of Waste guidelines. We saw posters advising staff of these guidelines.
- Disposable curtains around the cubicles were clean and stain free with a clear date of first use indicated on them.
- The children's department main entrance and corridors were clean and uncluttered. The anaesthetic and pre assessment room was visibly clean and free of clutter. However, during our unannounced visit, we noticed three unused cots/beds were stored in one of the back corridors, opposite to school playroom on T11S. Staff told us that there was no other place to store these.

- In NNU, the corridors were clean and brightly lit. However, there were several small pieces of equipment stored in the corridor and around nursing station. Staff told us that storage space was limited.
- The play specialists we interviewed explained the system of toy cleaning and showed us the rota. Staff showed good understanding of how to clean the toys and all toys were visibly clean and in good order. However, staff told us that there was no toy cleaning policy and other than a weekly schedule on a wipe board and no records were kept of the cleaning schedule for monitoring purpose. The trust later told us that there was no separate toy cleaning policy as that would be covered in the general cleaning policy of the trust and the schedule for toy cleaning was signed off by the play specialists for each of the wards and monitored by the play specialist team.

Environment and equipment

- We found clinical areas to be clean, well lit, bright environmentally child friendly with appropriate equipment. The playroom on T11S, activity room on T12S, and hospital school were well equipped with IT equipment and children's books. The large play room was well equipped with toys, craft materials and distraction materials. The playroom was open 24 hours, seven days a week and children used the room out of hours under supervision of a parent or staff member. There was a well-equipped sensory room called "sunshine room" for children on T11S. However, on T12S, we noticed broken lockers opposite the nurse's station that were used by staff and had staff belongings in, we raised this as a concern and staff told us that there were insufficient lockers.
- Paediatric and neonatal resuscitation trolleys were available in all areas. We inspected the resuscitation equipment throughout children's services including T11S, T12S, and NNU and in the transitional unit for babies. The trolleys were clean and secure, fully stocked and had been checked and logged on a daily basis. However, there were seven days in February 2016 when the resuscitation trolley on T11S was not checked and in one instance, it was used in between not being checked. We requested for the records of previous months and staff told us that the trust resuscitation team kept the monthly records centrally for audit purposes.
- The children's outpatient department environment was suitable for patients in both areas. Furniture was clean and water dispensers were available.
- The neonatal unit and the other clinical areas of children's services had sufficient equipment to provide safe care to premature babies and sick children. Staff we spoke to were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention. We inspected a range of clinical equipment throughout children's services and found it was up to date and fully maintained. However, we found some equipment that had passed the service date, including one mobile hoist on T12, an incubator, a blanket and a phototherapy unit and an oxygen flow meter on NNU.
- We checked the medicine refrigerator, the breast milk refrigerator and the domestic refrigerators. All were compliant and up to date with cleaning schedules and temperature monitoring.
- Breast feeding pumps on T11S were available for mothers. NNU had plenty of breast pumps and there were comfortable special chairs for mothers to express milk and breast feed.

Medicines

- The trust audited a wide range of medicines safety indicators to assess how they were performing, and to identify areas for improvement. These included preventable dose omissions, recording of allergies, and medicine security. These indicators showed that improvements were being made in all areas.
- Staff told us that the pharmacy team were a valuable resource in identifying issues with medicines and encouraging improvement. In all of the areas we inspected there was good clinical input by the pharmacy team, providing advice to staff and patients, and making clinical interventions with medicines to improve patient safety. Nurses could describe to us how learning was disseminated to them from the pharmacist by way of bulletins, emails and attendance at meetings.
- The trust had begun implementation of an electronic prescribing and medicines administration system, which had improved compliance with the standards for prescription documentation and clarity and reduced the number of preventable dose omissions. However, some staff on the ward told us that during the implementation

period there were higher incidents of medication errors. We were told that this had since improved. They received weekly emails from pharmacy about medication errors or omissions.

- Medicines were stored securely including controlled drugs and medicines requiring cold storage. On T11S and T12S medicines were kept in appropriate cupboards, all cupboards were locked in a locked room. Fridge temperatures were monitored daily including minimum and maximum temperatures.
- In the NNU, all control drugs (CDs) were recorded appropriately and checked twice daily by two nurses and monthly by the pharmacist, including those requiring cold storage. Expiry date checks were also done and short dated infusions were checked daily. However, on T11S CDs checks were missed on three occasions in previous months. There were 17 days when the drugs were only checked once in 24 hours instead of twice daily. We also noted that a number of oral medications and creams that were in use, but these had no label to indicate when the contents were opened.
- In NNU, we saw that parenteral nutrition was individually prescribed and available when needed. Arrangements were in place to cover weekends. Parents could be involved in administering their baby's medicines when they had been taught to do so safely by nurses, prior to discharge.
- Reference materials and formularies were available for doctors and nurses to refer to when prescribing or administering medicines. These were available in electronic and hard copy.

Records

- We looked at five sets of patient notes in each area, fifteen notes in total. All notes were clear and detailed. Entries were dated, timed and signed with the grade of doctor and nurse who reviewed the patient. In all cases, a consultant saw children/babies within 12 hours of admission, management plans were documented, nutritional assessments and pain scores were recorded, there was evidence of antibiotic review and evidence of daily wards rounds .
- In the NNU, patient records were multidisciplinary where all professionals including therapist and nutritional team could contribute to the individual baby's record. The notes included different coloured sheets to show records of different MDT input including psycho- social support, therapy and developmental care interventions, and parental discussion. On T11S and T12S nursing and doctor's notes were kept separate, we noticed that doctor's notes were stored securely in locked trollies. However nursing notes were stored in files by each cubicles on open shelves on T11S and near nursing station on T12S. This did not provided patient confidentiality.
- Parents and children were actively involved in care planning and the notes we looked at showed physical and emotional needs of children and families were documented. A Consultant on the NNU told us, they encouraged parents to write in their baby's notes.
- The surgical safety checklist recommended by the World Health Organisation (WHO) is a system to safely record and manage each stage of a patient's journey from the ward through the anaesthetic and operating theatre. The checklist was completed in all post-operative patients' notes. However some had not been signed or dated.
- In the outpatient department (OPD), patients' notes were available for various clinics. Staff told us that medical records would not be available if less than 48 hours' notice was given. In such cases they generate a set of records called "plastics" which were scanned later into permanent notes. However, we saw a folder containing several sets (more than 20) of those notes waiting to be scanned for inclusion into permanent notes rather than being scanned into permanent notes quickly. Staff told us that they would inform the outpatient manager of this issue.
- Information governance was part of the mandatory training. However, staff compliance rates were 81% across children services and 90% in NNU, which was below the trust target of 95%.

Safeguarding

- The trust had a well-established children's safeguarding team of named professionals and employed two full time social workers. There was a named nurse, a named doctor and a named midwife in post for safeguarding children as required by Royal College of Paediatric and Child Health (RCPCH) child protection guidance. The designated doctor in the clinical commissioning group

supported the team. The later trust informed us that they employ one consultant social worker and one senior social work practitioner who both have a Masters in Child Protection.

- We reviewed the safeguarding children policy, which was in date. Staff we spoke with had a good understanding of safeguarding for both adults and children**.** Staff had access to the trust's safeguarding policy via the trust intranet and knew how to access the safeguarding team to provide advice and guidance when required. Staff told us this team was supportive in giving advice and assisting them when concerns were raised or information was required. In NNU, we saw a "safeguarding board" with relevant contact number and information for staff. There was a clear flow chart and information in the children's school on how to raise safeguarding alert. However, we noticed that there was inconsistency within the children's wards and outpatient department (OPD) for signposting safeguarding contact details. For example on T11S there was a list by the main reception with contact number but there was no designation or title of named nurse. On T12S the information was on coloured paper and not very clear. There were no signage or contact details available at the OPD reception area. Staff told us that they would look for the information on intranet. However the lack of clarity and consistency remained a problem.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a referral either themselves or directly with the safeguarding team. We were given examples of concerns they had identified and where referrals were made.
- The hospital schoolteacher we spoke with was fully familiar with the safeguarding processes and knew how to contact the lead nurse for safeguarding.
- Safeguarding training was part of the trust's mandatory training programme. In addition to the safeguarding children policy the trust had a "child safeguarding training requirement document" which states that all staff who provide direct patient care to paediatric patients were required to complete safeguarding children level 3 training every three years. We reviewed paediatric and adolescents divisional monthly performance report for December 2015 and January 2016 and department was not compliant with level two and level three safeguarding children training. For example in January 2016, 74% CYP staff had safeguarding children level two training and 88% staff had level three training. The trust told us that staff awaiting a face-to-face level three training slot were required to complete level two 2 in the interim. In NNU 100% staff were compliant with level one and two and 89% were compliant with safeguarding children level three training. The department recognised mandatory safeguarding training as a main area to focus in 2016 and their number one priority in their "children and young people 2015 annual review report.
- Access to NNU and ward areas was secure. There was swipe card access for staff. Patient and families had to use an intercom for admission to the wards. The department had a child abduction policy in place.
- Though staff showed good understanding of chaperoning a child to theatre and for accompanying a child for tests. However, we were informed that there was no trust policy at the time of our inspection and a policy was being drawn up and was nearing publication.
- There was a female genital mutilation (FGM) clinic and this service was set up to provide medical treatment and psychological help to girls aged 0-18 years who may have suffered mutilation or may be at risk, either in the UK or overseas. Very few of the referrals for the clinic came from the local area, as referrals were received from all over the UK and not just for the local community.
- Staff reported that apart from a small number of complex urology patients aged 16-18 years, children were not cared for on adult wards. The complex urology cases were cared for at Westmoreland Street. However, during our inspection we found that there were young people up to the age of 21 years who had been admitted to T12S (children's ward) owing bed pressures in the rest of the hospital. This was contrary to the hospital's policy on emergency and non-elective admissions and raised safeguarding concerns, when considered alongside that patients from T11S (under 12 years of age) were also sometimes cared for here. When we brought this to the attention of senior staff, it was addressed immediately and the former position of not admitting young adults past their 19th birthday was reinstated.

- However, there was no formal system for safeguarding supervision. Staff were offered ad hoc supervision from the safeguarding team, but no records were kept of this. Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). Senior staff with safeguarding responsibility told us that there was no formal system for safeguarding supervision. The trust did not have a supervision policy, but reference was made to supervision in the trust's safeguarding policy. Formal supervision for named professionals was available through another NHS Foundation Trust (including the safeguarding midwife and community midwives, who were expected to attend quarterly). The trust informed us that 'ad hoc' supervision was also available for any other staff member or teams of staff where individual cases created any concern or anxiety.
- Staff informed us that an external company delivered a two day course in early March 2016 on supervision skills. The aim was to enhance and develop the supervision skills of the existing named professionals and supervisors.

Mandatory training

- Staff told us that the all mandatory training was recorded on an electronic system, which showed at a glance staff compliance with various topics to cover. Staff received advance emails reminding them of scheduled mandatory training updates.
- Most staff we spoke with told us they were up to date with their mandatory training. However, data showed that children and adolescent service was not meeting the trust target of 95% for mandatory training and overall staff compliance was 89%. 89% staff were compliant with fire safety training, 88% with medicines management and 94 % with hand hygiene training. However, 100% staff were compliant with safeguarding children level one training and treating people with respect training and 99% with conflict resolution and risk awareness training.
- Across paediatrics, there were 12 nurses with advanced paediatric life support (APLS), two with European paediatric life support (EPLS) and 58 with paediatric immediate life support (PILS). In the paediatric emergency department, 11 nurses had APLS and there would always be one APLS trained nurse per shift in paediatric emergency department and wards as per RCN standards 2013. Trust informed us that in the neonatal unit the number of qualified neonatal nurses that have new born life support was 84 out of 85 (99%).
- The neonatal unit staff's compliance with mandatory training was 96% and above the trust target. 100% staff were compliant with level one and two and 89% were compliant with safeguarding children level three training.

Assessing and responding to patient risk

- Children and young peoples were monitored for signs of deterioration using a paediatric early warning score system (PEWS). This structured method for communicating critical information contributes to effective escalation and increased child safety. All staff showed good understanding of PEWS. The student nurses we interviewed told us that they regularly witnessed the trained nurses carrying out patient safety checks using PEWS.
- We reviewed sixteen patient's nursing charts and found that the PEWS was recorded in all cases. We saw PEWS score written clearly on the doors of side rooms or isolation rooms.
- Staff said that the use of these paediatric early warning scoring systems enabled them to monitor a number of indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required. Nurses said they were well supported by doctors when dealing with deteriorating patients and followed sepsis guidelines for any suspected sepsis case.
- Venous thromboembolism (VTE) risk assessment and thromboprophylaxis compliance was monitored monthly by the CYP service and was completed in 79% cases in December 2015 and in 77% cases in January 2016. This was below England average of 95% and 96% for those months. The trust provided the VTE assessment figures for March 2016, which was 82.7%. VTE training was part of the mandatory training and was at 97% for nurses, 94% for consultants and 80% for doctors and pharmacist.
- We observed a medical handover and found this to be well structured and detailed. A nurse in charge after completing the nursing handover joined the medical handover to share any relevant information.

- There were daily safety huddles at midday. We observed two safety huddles where staff identified safety issues, discussed any outstanding issues with a focus on safeguarding concerns and improving the discharge process.
- There were four high dependency beds on T11S and two on T12S. The critical care outreach team included the resuscitation team, and was called the Patient Emergency Response and Resuscitation Team (PERRT). Matron told us that the PERRT team assisted in the management of critically ill patients across the hospital and will come over to the wards and there was clear safer staffing and escalation policies and processes in place.
- The critical care outreach team includes the resuscitation team, and was called the Patient Emergency Response and Resuscitation Team (PERRT). Matron told us that the PERRT team assisted in the management of critically ill patients across the hospital and will come over to the wards and there was clear escalation process in place.
- The UCLH critical care unit occasionally admitted paediatric patients but we were told staff were not provided with paediatric training. However we were told that there were specific admission and escalation policies and pathways to support the care of sick children and adolescents in the critical care unit. This was not recorded on the risk register even though senior staff told us they considered it as a risk.
- There were arrangements in place for the transfer of critically-ill children to specialist centres by a third party registered provider retrieval service. Staff reported that they came to the ward to support them with this process as and when necessary.
- Royal college of paediatrics and child health (RCPCH) standard states that at least one medical handover in every 24 hours should be led by a paediatric consultant (or equivalent). This standard was being met at UCLH and the medical handovers we attended were detailed and informative. A computerised handover sheet was available for each doctor, which helped facilitate an accurate handover. All admissions and in-patients were presented by junior doctors, with detailed discussion between the consultants regarding the patient's management. We noted that there was appropriate awareness of safeguarding issues throughout the handover.

Nursing staffing

- The trust assessed staffing levels and skill mix based on the Royal College of Nursing (RCN) standards. They modified the Safer Nursing Care Tool (SCNT) of RCN, to use for children and young people department.
- Within the general paediatric ward, the whole time equivalent (WTE) establishment was 24.5 and there were 26.17 nursing staff in post as of November 2015 and were working above their establishment. On paediatric & adolescent day care unit, the establishment was seven WTE staff and there were seven WTE staff in post. On adolescent unit, the WTE establishment was 24.6 and 22.9 WTE staff were in post. The department met the 2012 Royal College of Nursing (RCN) staffing guidelines, which are a series of standards, which detail the minimum essential staffing requirements for all providers of services for babies, children and young people.
- The neonatal unit followed the British Associate of Perinatal Medicines standards for staff ratio, which included Intensive / high dependency care 1:2 and for special care 1:4. There was a requirement to have 20 nurses (inclusive of nurses in charge) on per shift to cover a 32 cot bed base which comprises of 21 intensive / high dependency cots, 11 special care cots and 12 transitional care beds (located on the maternity care unit). During our inspection there were sufficient nursing staff matching with the establishment, which was 134.17 whole time equivalent (WTE), including 7.10 WTE Band 8a advance neonatal nurse practitioners (ANNP), 21.82 WTE Band 7, 68.56 Band 6, 32.69 Band5 and 4.0 Band 4.
- Matron told us there were low to no vacancy on T11 and T12 as there were some staff on long-term leave. There were staff retention plans in place and most of their student nurses would like to come here and posts were advertised internally first.
- The vacancy rate on NNU was 12.8% WTE. Staff told us, though they had staff retention plans that included self-rostering, exit interviews with staff leaving the department to analyse the reasons, there was a national shortage for this specialty due to which there was high

reliance on agency and bank nursing staff. Senior nursing staff raised concerns with us that average agency staff usage was 13% during day and 33.5% at night. Staff told us that incident forms would be completed when agency use was high and we noted that this was on their risk register.

- Senior staff told us that the risks of using high numbers of agency staff was minimised by using regular agency staff and that they received a comprehensive induction.
- There were daily nursing handovers, one at 8 am and one at 8 pm with a safety huddle at midday. We observed two nursing handovers, which were well structured and comprehensive. At the end of handover a safety briefing checklist was used which identified: patients with infections, medication, sick patients, patients at risk of falls, hand hygiene, safeguarding, pressure areas, , documentation assessments, care plans, community referrals, staffing levels, medical team level, equipment and stock level. This was a well-imbedded practice throughout the children wards and NNU.
- Some staff told us it could be difficult due to staffing numbers if children admitted from A&E were placed on an enhanced level of observation due to their mental state. Therefore, registered mental health nurse (RMN) shifts sometimes went out to agency at short notice. This was recognised as an issue by senior staff and a business case had been submitted for two band 3 support workers trained in mental health and one part-time RMN to support them.
- The trust employed a team of 18.7 WTE play specialists. There were dedicated play specialists for each paediatric area including wards, outpatients, theatres, emergency department, dental department and other paediatric specialities.
- We interviewed three student nurses who told us that they were well supported on their placements by their allocated mentors. They confirmed that they were supervised according to Nursing and Midwifery Council (NMC) regulations and spent at least 40% of their time with their allocated mentor. Nurse in charge showed us the rostering system on children services. Our inspection of the rosters showed that the staffing levels were compliant with the RCN recommended staffing levels, Roster were published six to eight weeks in advance and emailed to staff. Any gaps identified were allocated to bank nursing staff. Actual and planned staffing levels were displayed at the entrance to each ward area.
- Matrons and charge nurses we interviewed told us, there were always enough nursing staff on duty and were able to share paediatric nurses between T11 and T12 if required to ensure safe numbers. However, some nurses stated that they did not like to be redeployed to another area.

Medical staffing

- The Paediatric department had 75 WTE (whole time equivalent) medical staff. The proportion of consultants (31%) was just below the England average (35%), and proportion of registrars (69%) was higher than England average (51%).
- A consultant paediatrician was available on site from 8:30am to 9pm weekdays and during the daytime at weekends (up to 4:30 pm) with one paediatric consultant available overnight and at weekend. There was a haemato-oncology consultant on call 24 hours a day, seven days a week. A consultant endocrinologist was available on site from 8.30am -5pm weekdays and there was a joint on call rota with another specialist children hospital 24 hour, seven days a week.
- All the paediatric urology surgeons working at UCLH had joint appointments with neighbouring paediatric specialist hospital. The adolescent surgeons were directly employed by UCLH. There was a joint on-call rota for both UCLH and another specialist children hospital, where by the medical teams out of hours cover both sites. The aim was to manage waiting lists for both hospitals as one, so that patients are seen as promptly as possible in a safe and age appropriate environment.
- The paediatric surgeons working at UCLH were jointly appointed with another specialist paediatric hospital.
- There were additional 3.5 WTE middle career staffing consisted of two WTE general paediatrician, one WTE oncology paediatrician and 0.5 WTE endocrinology paediatrician.
- The junior doctor rota included 23 WTE paediatricians including general paediatric, paediatric oncology specialist registrars and senior house officers. There was sufficient junior doctor cover during daytime, however

there was one general paediatric specialist registrar and one general paediatric senior house officers for night cover. Concerns were raised with us that junior doctor cover at night was not sufficient as they covered four wards and emergency department, especially when general paediatric doctors had to care for oncology patients on northwards without any specialist training in oncology. However, they did say they were supported by their consultant when they needed advice.

- The department was compliant with the Royal College of Paediatrics and Child Health (RCPCH) "facing the future" criteria with regard to patients being seen by a consultant within 24 hours of admission.
- There were 11 WTE medical staff on NNU. Consultants were available on site and on-call to babies on the neonatal unit 24 hours a day, 7days a week and there was always a doctor of sufficient seniority (ST5 or above) on the unit. Nights and weekends cover included one consultant, two specialist registrars and two senior house officer.

Major incident awareness and training

- We examined the major incident plan, which was available on the trust intranet. Each ward also had a "purple folder" with relevant information related to the trust major incident plan and key contact numbers. All staff we spoke with were able to describe the process to follow in case of a major incident including fire and winter preparedness and all staff had received training at induction.

Are services for children and young people effective?

Good

We rated the children's service at UCLH as good for effective. This was because.

- Care and treatment reflected current evidence-based guidelines, standards and best practice. The service participated in a number of national and local audits to measure their effectiveness and to drive improvements. Performance against the national neonatal audit programme and the national diabetes audit was better than the national average and there was evidence of local action plans to address any issues identified.
- Pain was being effectively managed and regularly monitored. Nutrition and hydration was effective and was being monitored with dietician input when needed. .
- Consent to care and treatment was obtained in line with legislation and guidance. Staff could demonstrate a good understanding of Gillick competence. Staff involved parents and children in decisions about care and treatment.

However, whilst there was evidence of multidisciplinary working, access to physiotherapy and occupational therapy was limited to Monday to Friday. Staff could access an on-call physiotherapist over the weekend but reported this was shared across the whole trust, therefore limiting access.

Evidence-based care and treatment

- Care was provided to children and young people in accordance with national guidance, including guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPH). Policies were based on NICE and Royal College guidelines. Although evidence was seen of recent activity in reviewing policy and guidance, there was no chaperone policy and following our inspection the trust told us this was being developed.
- Staff demonstrated how they accessed guidance, policies and procedures on the trusts 'insight' page on the trust intranet. Staff told us the guidance was clear and comprehensive and updated frequently.
- Appropriate care pathways were in place for children with long term conditions e.g. asthma or diabetes
- The paediatric service audited their compliance against both NICE and British Thoracic Society(BTS) guidelines for the diagnosis and treatment of asthma. The asthma audit assessed compliance in an outpatient clinic and children presenting at the emergency department with acute wheeze. A previous audit had identified that many key performance indicators (KPI's) appearing in the guidelines were not documented in case notes. Due to this the service had introduced an integrated care pathway for use in the emergency department and template letters in the outpatient clinic to ensure key information was documented. This has led to an improvement in documentation in a number of areas

including wheeze severity, provision of written care plans and delivery of training in inhaler use. The service was now able to regularly measure their performance against KPI's to ensure on-going compliance.

- The hospital has received full accreditation in UNICEF's Baby Friendly Award that recognises good work around ensuring mothers and babies receive high quality support to enable breastfeeding.
- We saw evidence of a number of local audits being undertaken within the children's services including hand hygiene, timing of cultures, documentation and quality of prescribing. Local audit activity results were displayed at the entrance or at a focal point for parents within the hospital and included hand hygiene and friends and family test (FFT).
- General Paediatrics has plans to undertake further audits to assess compliance against NICE guidelines including eczema and urinary tracts infections in infants, children and young people under 16. These audits were not currently completed.

Pain relief

- We observed staff using a variety of age appropriate pain tools. The pain assessment chart was embedded in the Brighton Paediatric Early Warning Score (BPEWS) chart. For younger children staff used the 'Wong-Baker smiley FACES' where children were asked which face best described their pain. We observed a numerical rating scale being used with older children who were asked to describe their pain on a scale of one to 10. In the case of smaller children or for children living with a learning disability a Face, Legs, Active, Cry and Consolability (FLACC) behavioural tool was used.
- On T11S, a treatment room was used for any painful or distressing procedures. Staff told us this was to prevent other children becoming distressed and to keep the bed space a comforting place for the child.
- We saw nurses and doctors using a distraction therapy approach for children and young people, which was led by the play specialist. This was a way of helping a child cope with a painful or difficult procedure.
- We saw that the NNU used Kangaroo care (a technique where the baby was held skin-to-skin with the parent) as a means of helping to stabilise neonates temperature.
- Patients and their parents told us that their pain was managed well. One young person commented "the pain relief is good here, they ask me if I am in pain and support me when I am".
- The NNU did not have a current pain assessment tool in use. Staff identified this as an area for improvement and there was an on-going strategy to introduce this. However, we were not given a planned date of introduction of this tool.

Nutrition and hydration

- The paediatric service's used an adapted Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) to assess nutritional risks. Nurses told us STAMP helps them identify whether they should refer patients to a dietician. We saw nutritional screening assessments completed in all fifteen of the patients' notes we looked at.
- Staff on the NNU told us they had their own NNU nutritionist if a baby was not gaining weight. There was also a multidisciplinary nutrition group once a week to discuss babies having difficulty putting weight on. Staff showed us copies of the plans that were put in place to help babies gain weight.
- Patients with poor food and hydration intake were identified and observed closely by the nurses. Staff could access a dietician if required and patients records showed evidence of input from the dietetic service where young people were at risk of malnutrition.
- We spoke to five parents in the outpatient department and one of them said "I can email the dietician directly for support and always get a response".
- Parents and children commented that there were choices on the menu offered each day and that the food provided was "good", "ok" and "fine". Snacks were available throughout the day. Halal and Kosher food was available on request. We saw all children had drinks by their bedside.
- The NNU special care team has access to milk from the donor bank and breast pumping facilities were available. Donor breast milk was accessed from another hospital in London.

Patient outcomes

- In the 2014 Children and young people's survey, the trust performed better than or about the same as other

trusts on questions around staff working well together, care being planned with parents, the hospital doing everything possible to ease children's pain and different members of staff being aware of children's medical history.

- The trust performed well in the National Paediatric Diabetes Audit 2013/2014. The actual (unadjusted) percentage of children with an HbA1c less than 7.5 (or 58mmol/l) was 34.6% compared with an England average of 18.5% (a high percentage is better). HbA1c levels are an indicator of how well an individual's blood glucose levels are controlled over time. Children and parents were asked to complete questionnaires about the diabetes service and 76% reported a high level of satisfaction compared to the England and Wales average 55.8%.
- The NNU participated in the National Neonatal Audit Programme (NNAP) in 2014. . The service performed better than the national average in a number of key indicators. 95% of babies discharged home from UCLH neonatal unit were receiving some breast milk compared to 60% of babies nationally. 94% of mothers (with babies born between 24 and 34 weeks gestation) at UCLH received antenatal steroids compared to 85% nationally. 100% of babies at UCLH were screened for retinopathy of prematurity (RoP) with 95% screened on time in accordance with national guidelines, this compares to 93% of babies being screened on time nationally and 97% of eligible babies having screening at some stage. 100% of parents at UCLH had a documented conversation with a senior member of the neonatal team within 24 hours of admission compared to 89% nationally. 100% of babies born before 30 weeks gestation discharged home from UCLH had a follow up assessment with documented health data at 2 years of age compared to 46% nationally. 100% of babies <29/40 had their temperature measured on admission compared to 94% nationally.75% of babies had a temperature in the normal range but 15% of babies had a temperature below 36 compared to a national average of 12.4%.
- The maternal new-born infant clinical outcome review programme (MBRRACE-UK) published its unit specific data for babies born in 2013. This compared the NNU against other similar services across the UK. The service performed better than the national average for level 3 NICU with mortality rates 10% lower than the average for stillbirth, neonatal death and extended perinatal death.
- The National Data Analysis Unit (NDAU) looks at mortality rates across all the trusts in the UK. The NNU had a mortality rate of 0.57 which was better than the national average 1.0.
- There were no emergency readmissions for children under the age of one. Non-elective readmissions in paediatrics were lower than the England average in all age groups (0.6 locally compared to 2.7 England average).
- Medium length of stay was in line with the England average for non-elective care of children aged one to 17.
- Elective multiple readmission rates were worse than the England average for clinical haematology (2.2 locally compared to 1.7 England average) and paediatrics (1.7 locally compared to 0.9 England average) in the one to 17 year old age groups
- The trust took part in the National Children's Day Case and Inpatient Survey 2014. There were 112 respondents in the survey and the trust was benchmarked against 70 other trusts. The trust scored worse than average in changing dates of hospital appointments, hospital food and access to hot drinks, staff not talking to the child about their worries, talking in front of the young person as if not there, parent's perception of privacy, young person not involved in decisions and overnight facilities for parents.
- The Paediatric divisional annual audit programme lists a yearly safeguarding adolescents audit. Trust informed us that a comprehensive audit against section 11 of the Children Act was provided to the LSCB in 2014. However, we found no evidence of joint Local Safeguarding Children Board (LSCB) audit plan and trust informed us that the LSCB audit plan was being finalised at the time of the visit.

Competent staff

- Staff told us there was good access to training. The trust circulated emails detailing what training opportunities were available to staff. The NNU had training sessions throughout the week for staff and we saw copies of the

timetable and there was good support when they needed to attend external courses as part of their skill development. Nursing staff told us that there was funding available to do postgraduate course.

- Following an incident, all staff were offered conflict resolution training and 99% of staff were now trained in this.
- All staff we spoke with had access to supervision from senior nurses and told us they received a good level of support from their managers.
- All junior doctors we spoke with confirmed that they had an allocated educational supervisor. They described how different cases were discussed at the weekly training sessions to allow for learning.
- The NNU was voted as the best teaching in paediatrics by all paediatric trainees in the London deanery.
- Revalidation for nursing staff was in line with Nursing and Midwifery Council requirements. Staff said their managers supported them to attend regular training for their continuing practice development (CPD)
- The NNU monitored staff competencies and helps staff develop so they can progress within their roles. The nurses we spoke with on the day confirmed there was good opportunity to progress.
- Student nurses said the induction at the trust was good and covered many topics enabling them to fulfil their role effectively.
- The trust's annual review of children and young people's services identified that compliance with level three safeguarding training remained low at 88%. 74% of staff were trained in safeguarding children level two. The more recent safeguarding training data provided to the CQC from the 8th March 2016 showed the Paediatric & Adolescent Division was at 90% for level two training and 87% for level three. Royal College guidelines recommend all staff working with children were trained to level three.
- All the nurses we spoke with said they had an appraisal within the past twelve months. The NNU falls within the maternity and neonatology division and 96.9% of registered nurses and midwifes had their appraisals which satisfied the trust target of 95%. However, the trust provided data showing 89.3% of registered nurses in the paediatric division had their appraisal, which was below the 95% trust target.
- The paediatric and adolescent monthly divisional report published in January 2016 showed that 75% of paediatric staff were trained in Paediatric Life Support. Trust informed us that on 8th March 2016, 92% of paediatric staff were trained in Paediatric Life Support, following additional training opportunities
- 100% of medical staff had their appraisal. All doctors we spoke with confirmed that they were up to date with their appraisal and training doctors were working towards their revalidation.

Multidisciplinary working

- We observed good working relationships between all grades of staff and all professional disciplines. Staff we spoke with said there was no hierarchy in the clinical teams and everyone was equal.
- Handovers included the whole multidisciplinary team (MDT) such as doctors, nurses and therapists. There was an additional MDT handover during the week to ensure effective information sharing. One parent said "everyone links up, education, play specialists and nurses".
- There was access to dedicated physiotherapists, occupational therapists, social workers and play specialists. Parents were very positive about the play therapists. One young person said "the play therapist encourages me to do things so I am never bored".
- We looked at fifteen sets of patient's records and all of them showed evidence of MDT input.
- There was access to psychiatry and psychology services through the Child and Adolescent Mental Health Service (CAMHS). The division had a "Psychological Medicine service" for the provision of emotional support, which incorporates CAMHS, psychiatry, psychology and psychotherapy" who see patients on all four paediatric wards and as outpatients. Trust informed us that there were also designated ward based social worker and health visitors who provide emotional support and advice and linked with community and primary care. Staff told us this had been very useful due to a number

of serious incidents involving young people with mental health needs. Patients were very positive about the psychology service. Staff told us they can speak to the psychologist themselves during challenging times.

- Transition of young people within the specialist young people's service in UCLH ranged from the age of 13 to 24 years of age.There was a dedicated adolescent in-patient and out-patient service. Adolescent MDTs and network meetings were organised within the department. Transition special interests group was set up in October 2015 by the CNSs to share information & improve delivery of the transition service. The team was working on a transitioning guidelines document to formalise and streamline processes. There were specific transition clinics, from both paediatric services to adolescent services and from adolescent to adult services, for example, for paediatric urology and children and young people cancer service. There were joint MDT meetings and liaison with adult services for example in paediatric and adolescent endocrine service and there were joint transfer programmes between diabetes adult service providers.
- The NNU and wards had access to a full time pharmacist. Staff told us the pharmacist was accessible when needed.
- Staff on the NNU told us they had fixed reserved slots for MRI scans and good access to CT scans when required for paediatric patients.
- The trust performed better than other trusts for the question in the Children and young people's Survey 2014 about whether members of staff caring for children work well together. The trust performed "about the same" as other trusts for all other questions relevant to the effective domain including care being planned with parents, children's pain management and different members of staff being aware of children's medical history.

Seven-day services

- Support services such as imaging, occupational therapy, physiotherapy were available Monday to Friday. Physiotherapy was available on call over the weekend and imaging was able to be accessed through the accident and emergency department out of hours.
- There was a consultant paediatrician for general paediatrics available on site from 8.30am till 9pm Monday to Friday and during the weekends until 4.30pm, with one paediatric consultant available overnight. There was a joint on-call consultants rota of UCLH and another children specialist hospital 24 hours, seven days a week.
- The NNU had access to a consultant seven days a week and they were available outside of normal working hours through the on-call weekend rota and on-call system.
- Staff we spoke with told us access to therapy over the weekends was limited as the trust had one physiotherapist on call for the whole hospital. One parent said sometimes it would mean waiting till Monday to be seen.

Access to information

- Guidelines and protocols were accessible to clinical staff on the trust intranet. Staff told us they could access information in a timely way.
- The NNU had a range of leaflets available for parents. Staff provided parents with a 'my pathway home' booklet which had a checklist of key things for parents to do such as immunisations and hearing tests.
- T11S and T12S had a variety of information leaflets available on a range of different topics and conditions. For example: postnatal depression, accidents to under-fives, how to feed baby, measles, heart conditions and female genital mutilation. These could be requested in different languages when required.

Consent

- We found that consent to treatment for patients was obtained following the correct guidelines and procedures. All staff spoken with were aware of the trusts consent procedure and could describe the legislative requirements regarding consent in young people. Staff were able to describe Gillick competencies and the requirements for seeking consent from children and young people when they had been assessed as competent to make decisions about their care and treatment. The Gillick competence is a test in medical law to decide whether a child of 16 or younger was competent to consent to medical examination or treatment without the need for parental permission and knowledge.

Services for children and young people

- Parents on the wards confirmed that their consent had been sought prior to treatment of their child. They described how staff gave them clear information and answer any questions. Staff gave parents a copy of the consent form and we saw evidence of signed consent forms in patient records. Staff involved young people and parents in the decision-making process regarding care and treatment.
- We observed staff following trust policies. On T12 staff prevented a young person going for surgery due to the parent who signed the consent form was not available to chaperone.
- The NNU had up to date and useful policies readily available in a 'red drawer' which staff could access when required.

Are services for children and young people caring?

Good

We rated the services for children and young people as 'Good' for caring. This was because:

Children were cared for in a caring and compassionate manner. Their privacy and dignity was maintained throughout their hospital stay. Staff ensured that children and their families were informed about their care and were fully involved in any treatment decisions.

Parents were supported to have an active role in the care of their child. They were encouraged to ask questions and learn how to support their child or baby prior to discharge. Emotional support was available to patients and their families across the service.

Compassionate care

- We observed staff treat patients and their parents with dignity and respect. Nurses and doctors introduced themselves to patients and their parents. Where appropriate, staff asked older children if they would like to speak in the presence of their parent or not. Curtains were drawn around bed bays when privacy was needed. Signs were present across the wards reminding people that confidential conversations could be overheard in public areas.
- Interactions between staff and patients were positive across the service. Nursing staff reassured children and their parents and answered questions about their care. They made sure that children and parents were informed about procedures they were about to undertake and listened to children's points of view. This finding was confirmed by results of the National Children's Day Case & Inpatient Survey 2014, where the department performed better than other trusts in questions relating to communication and information provision.
- Staff had a caring, compassionate and sensitive manner. We saw staff playing and laughing with children and talking to the babies in the neonatal unit whilst performing observations. Children reported that the nursing staff entertained them when appropriate and stopped them from getting bored. A child in the paediatric outpatient's department told us, "The doctors and nurses are kind".
- Consideration was given to the wellbeing of the entire family. One mother with a baby being cared for in the neonatal unit commented that she was in the eyes of staff, "just as important as my baby". A father with a nervous system disability was supported to be involved in the care of his child.
- In the neonatal unit, results from the 'Your Experience Matters' survey from March 2016 were largely positive –100% of parents said they were listened to by staff, 93% of parents agreed that they were encouraged to support and feed their baby and 100% of parents said that the unit maintained confidentiality effectively.
- There were many cards and pictures in each ward from former patients and parents that had utilised the service, commenting on how good their care experience had been and how dedicated the staff were to their roles.
- Friends and Family Test (FFT) results were consistently good across the department. For the period of September 2015 to February 2016, FFT scores for the neonatal unit varied between 90% and 100%. In the same period, the mean FFT score for T11S was 98% and for T12S was 95.9%.
- Two parents that we spoke to had largely positive comments about the service but a few minor issues. One parent commented that information sharing

between staff could be better on occasion. Another parent commented that the doctors were not always as forthcoming with information as she would like but that they always answered her questions when prompted.

Understanding and involvement of patients and those close to them

- Staff were described as having a high level of expertise and helped to involve parents in the care of their children and babies. A mother in the neonatal unit commented that she was encouraged to have "ownership" of her baby. She said she was always asked about what she had noticed about her baby and how she thought he was doing. Other parents in general paediatric ward commented that staff took their point of view on board and always kept them informed of clinical decisions.
- Children reported being well-informed about their care and able to take an active part in their treatment decisions. One adolescent inpatient told us, "If I say I don't want anything, they listen to me. They are very supportive and ask me about my pain." Another child in the outpatient department reported, "They tell me what's happening – that means I don't feel afraid".
- We observed a ward sister speaking to a young person going home on weekend leave about her care and answering any questions she had about what to do over the course of the weekend.
- Discussions with patients and families were evident in all of the notes that we examined, including in discharge planning, decisions to transfer to other hospitals and gaining of consent. Family involvement and education was also discussed in the handovers that we attended in each ward.
- In the neonatal unit, parents were able to ring and check on their baby on direct telephone lines installed in the room where their baby was cared for. A mother we spoke to in T12S reported that the consultant provided their mobile number so she could ring him at any time with questions.
- Parents were actively encouraged to gain skills in caring for their babies in the neonatal unit. There were twice weekly parental education sessions which were available to all parents. Teaching and skills records were present in five sets of notes that we looked at, which were signed by a qualified nurse when parents were able to undertake tasks such as nasogastric feeding.
- Young people were used on interview panels to recruit new staff to the service. Senior staff reported that they asked more direct and relevant questions that helped decide which candidate had the right skills to work with children and young people.
- There was involvement of young people in the development and evolution of the website for the service. This was designed for use of children with different requirements and expectations from their hospital experience by age group (0-6, 7-12 and 13-19).

Emotional support

- There was psychological support available for patients and their families across all wards from a psychotherapist or counsellor. An adolescent in T12S described her regular psychology input as "great". A psychotherapist in the neonatal unit held regular coffee mornings with parents and was available to offer support. A mother of a child in T11 reported she saw a counsellor at the Macmillan centre once a week.
- In the neonatal unit, there were records of discussion around psychosocial support and a checklist to encourage developmental and therapeutic care in each set of notes. These included tips to prevent peaks in stress when caring for your baby and advice around skin-to-skin contact to encourage attachment between mother and baby.
- Play specialists supported children by preparing them for treatment and teaching them coping strategies. This reduced the anxiety of the child and increased treatment compliance. Two parents told us that the presence of the play specialists meant that their children were happy to attend scans and appointments they would have otherwise found difficult.
- Staff were aware of the procedures to follow in the event of a bereavement of a child or baby. Support was offered from the palliative care team, who reviewed patients regularly and would come to the ward at any time if needed. There were two palliative care nurses on call at all times. A bereavement pack was available for parents in both the paediatric wards and neonatal unit to help remember their children or baby.

Services for children and young people

Are services for children and young people responsive?

Good

We rated the services for children and young people as 'good' for responsive. This was because:

Services were designed appropriately to meet the needs of children of different ages.

On the whole, admission and discharges from each service were managed well, with the help of daily capacity and bed meetings within each department. There were some issues with capacity in the neonatal unit. The needs of individuals were considered and largely met by the service.

Complaints were dealt with informally. However, staff had little awareness of formal complaints or learning from these.

Service planning and delivery to meet the needs of local people

- Staff told us that the hospital drew patients from a much wider catchment area than just their immediate surroundings. This was supported by the service line agreements the trust had in place for services such as the female genital mutilation (FGM) clinic.
- T11 had an activity room with toys and games appropriate for those under 12, T12 was furnished with a recreation room and there were provisions appropriate to those aged 13-17 years.
- The children's outpatients department had separate waiting areas for younger and older children, with age appropriate decoration and activities.
- We observed other departments across the hospital where children and young people would visit as part of their care and treatment. The majority of these areas were equipped to be 'child friendly', such as the dedicated operating theatre, waiting area and recovery area.

Access and flow

- T11S admitted children aged 0-12 years, mainly from paediatric A&E, who had been assessed by a senior doctor as requiring admission. There were seven cubicles for patients requiring isolation or with more complex needs. This had been increased from five cubicles last year to improve issues with flow from the A&E department. There were also eight bays, of which four beds were high dependency. Average bed occupancy in the period of April 2015 to February 2016 was 50%. Attached to T11S was a separately managed six bedded bay for day cases.
- A parent reported that the transition process from A&E to the ward was quick and easy. Their child had scans and bloods taken and were admitted to the ward, "very fast – much better than in other hospitals".
- A paediatric admission assessment sheet was used for children being admitted to T11S, which included their reason for admission, admitting observations and tests, medical history and also aspects of their social history. This was only partially filled out in some records we looked at. Staff said that this was because the average length of stay in the ward was only around 1.5 days and this information was not necessary in all cases.
- T12S took mainly elective admissions of 13-18 year olds. A range of surgical and medical specialities was referred here, as well as consultations for chronic fatigue and chronic pain, for which two beds were ring-fenced per week. There were a total of 16 beds and four side rooms. An extra five beds were available however, there was no funding available for these and therefore could not be used to increase patient numbers. However, staff told us that these were sometimes used to avoid gender breaches, although this rarely happened. Average bed occupancy in the period of April 2015 to February 2016 was 66%.
- There was a daily bed management meeting with senior staff from T11, T12S and day care to discuss planned admissions, discharges and staffing ratios. Staffing levels were adjusted across the wards to ensure that patients with complex needs had the correct number of staff to care for them. Patients could also be moved from T11S to a cubicle in T12S if required, although the matron confirmed that only the oldest and least dependent patients were transferred. Under 13s were not cared for in bays there.
- Staff and patients reported that the discharge process worked well, as a whole. Discharge planning involved the multidisciplinary team and the family to ensure children's needs were met holistically. A mother we

spoke with confirmed she had been involved in the discharge planning process and that community support from local agencies was being sought to support her child at home. We observed discharge planning being discussed in handovers, bed meetings and at the daily safety huddles at midday.

- According to the service's annual report, there were over 1000 admissions last year to the neonatal unit. The unit had 21 cots in nursery one, which were a mixture of intensive care and high dependency cots. There were also 11 cots in the special baby care unit (SCBU) and 12 transitional care cots. Babies mainly came straight from the attached labour ward but were transferred from all over London if requiring Level 3 care.
- Cot occupancy in the neonatal unit was at 103% at the time of the inspection. Although the unit has the ability to open an additional two cots if required, staff we spoke to confirmed that capacity could be an issue. This was because there were regularly more cots or incubators in each room than they were designed for.
- Due to the need to maximise clinical space, a lot of equipment was stored in corridors due to lack of available storage areas and there was only one staff toilet.
- There was a daily capacity meeting in the neonatal unit to try and anticipate patient movement and plan for this. Medical and nursing staff attended as well as the discharge nurse and staff from the labour suite, to inform the unit of pending deliveries that may require admission.
- Arrangements were in place for the neonatal transfer service to transfer children to other specialist centres as appropriate. The unit transferred patients to appropriate paediatric units across London and were part of the North Central London network. There was an information board dedicated to transferring care in the reception area with a range of information on this process for parents. They were advised to visit their local unit ahead of time with the help of the outreach team. Staff told us that these arrangements worked well.
- There was a booklet entitled, 'My Pathway to Home' in each set of neonatal notes which drew together all the key information and referrals for each baby. There was a section relating to preparation for discharge which included details of any follow-up appointments.
- There was an advanced neonatal practitioner nurse clinic which addressed issues such as early jaundice, weight gain and a range of other concerns. This linked with the community postnatal service and meant babies could be discharged from there instead, if appropriate.
- In the paediatric outpatient department, clinics were rarely cancelled with less than six weeks' notice. In this case, the appropriate medical secretary to reschedule their appointment would contact them. If a patient cancelled an appointment, staff were usually able to reschedule this immediately. We observed a follow-up appointment being booked at a time convenient to the patient. Between August 2015 and February 2016 669 clinics were cancelled and majority (265) were for planned annual leave of clinician.
- If patients did not attend a scheduled outpatient appointment, reception staff would complete an 'outcome form' and their family would be contacted to find out why. They would be offered another appointment slot at a convenient time.
- Late running clinics were not observed to be an issue. The department had recently increased the appointment length in the pre-assessment clinic for surgery to help with this. A parent confirmed that clinics usually ran on time. They reported that they were kept informed by the receptionist if they had to wait longer than expected.
- We spoke to seven parents in the paediatric outpatient department who were very happy with the service as a whole. One parent described being able to change appointments at short notice and another commented, "I can email the dietician [from the nutrition and allergy clinic] directly and get a fast response".

Meeting people's individual needs

- Photographs and names of ward staff were clearly displayed in each ward.
- Laptops and mobile phones were allowed in both T11S and T12S. Both staff and parents took responsibility for ensuring children were using the internet appropriately.
- Translation services were available both over the telephone and in person. Staff confirmed that this

service was easy to use and there were usually no problems with interpreters attending the wards. They were able to give examples of times they had used the service recently.

- Some patient information leaflets were available in Arabic on T11, but all other patient information only indicated it was available in other languages or formats on the back of each leaflet.
- A multi-faith chaplaincy was available to all wards. There was a quiet room used for prayer on each ward and staff also facilitated prayer where possible in cubicles.
- The children's outpatients department had separate entrance and separate waiting areas for younger and older children, with age appropriate décor and activities. A parent we spoke with said that there was "plenty to keep kids occupied while we wait", whilst a child commented, "It's a fun place, there are lots of games". However, some parents told us that there was no reception of mobile phones, which presented a problem as they leave children unattended while they go out and take the call.
- In theatres, there was a separate entrance and waiting area for paediatric patients. The waiting area had age appropriate toys and books. If required, a play specialist was available for distraction. Paediatric patients were recovered in a separate recovery area which had been made child-friendly with bright paintings on the walls. There was also a dedicated children's theatre with a child friendly anaesthetic room.
- Facilities were available for parents to stay overnight on both the neonatal unit and T11S. In T12S, parents did not usually stay by the bedside of their child if they were in a bay. Here, if parents wished to stay, staff booked parents into one of the three rooms available for this on T11S. This was to encourage young people's independence and also due to the lack of space. The department scored worse than other trusts on overnight facilities for parents in the National Children's Day Case & Inpatient Survey 2014.
- Halal and Kosher food options were available. There was a kitchen in each of the paediatric wards, were families could bring their own food for their child to eat, as long as it was labelled correctly. Kitchens included microwaves, toasters and kettles. Daily meals were routinely offered to mothers in the neonatal unit, with consideration given to specific dietary requirements.
- There were weekly groups in the paediatric wards where patients and families were encouraged to attend and give their suggestions on how the patient experience could be improved. Food ideas for new menus were tested in this forum and these children chose the company who painted new murals in the ward environment.
- In the neonatal unit, mothers were supported to breastfeed. The unit had six breastfeeding pumps and special chairs designed for comfort when expressing milk and breastfeeding. One parent commented that she wished this area was larger but the unit also lend pumps to parents to take home. There was also donor expressed milk available for preterm babies.
- The wards were accessible to people with disabilities – on T12S, the kitchen had recently been adjusted to ensure it was accessible to young people in wheelchairs.
- Patients with learning difficulties were generally well-supported in the paediatric wards. Most staff we spoke to were aware of the lead nurse for learning difficulties and how to contact him. They were able to describe different ways they would care for and communicate with these patients, using advice from families and carers. Hospital passports were in use to aid with getting to know each individual patient and their needs. Parents were encouraged to stay with their children if required; even on T12S, patients with learning difficulties were only admitted to side rooms, which ensured this was possible. However, staff reported that they did not have any specific training regarding caring for patients with learning difficulties, although the trust reports that this was included within safeguarding adults level one and two training.
- There was a sensory room on T11S called the 'sunshine room', which included lights, music, beanbags, a projector and various toys. This was often used for patients with learning difficulties who were waiting for appointments in the day care unit. A play specialist would help to assess any needs and lessen their anxieties. There were clinic lists for those with enhanced needs on Wednesdays of each week.

- On T11S, the treatment room was usually used for any painful or distressing procedures such as dressing removals or lumbar punctures. This was so the bed space remained a safe and comforting place for children.
- T11 had an activity room with toys and games appropriate for those under 12, including a football table, various toys, a computer with internet access, a games console, arts and craft materials and DVDs. T12S was furnished with a recreation room with magazines, computer, games, DVDs and other provisions appropriate to those aged 13-17 years. Both wards ensured that an activity timetable was in place and rooms were open for use 24/7.
- Psychological support was provided for children with mental health needs on the paediatric wards by the Paediatric & Adolescent Psychological Medicine Department. The trust estimated that approximately 20-40 patients per year were admitted to T11 or T12S whilst waiting for a mental health bed, or because they had medical needs that made it impossible for them to be cared for in a psychiatric ward. A recent incident had led to the psychological medicine service coming to the ward and advising on how the environment could be made safer. Staff were aware how to contact the team for support and told us they called the ward regularly to see if any assistance was required. Conflict resolution training was offered to staff and there was a mental health information folder on the neonatal unit, which had information about various relevant topics and policies relating to mental health care.
- Transitional clinics were held in the outpatients department to support those moving into adult care. In T12S, a nurse described how MDT 'track' meetings were held by a consultant and their team to help patients manage this change. Details of 'Minding the Gap', a transitions team in community for patients aged 17-18 years, were also on display in the ward.

Educational Services

- On T11S and T12S, there were school rooms provided by neighbouring specialist children hospital. Both were open during school hours in term time. Out of school hours, staff told us that the teachers liaised with the children's schools and teachers to put resources in place for revision or home work. Play specialists and nursing staff then supported them with this. Children we spoke with reported that they kept up with their school work whilst on the ward. A parent confirmed that the activities and work on the ward linked up with what her child was doing at school and that the nursing staff asked for her school report.

Learning from complaints and concerns

- There were 20 formal complaints for the paediatric department between April 2015 and March 2016. The majority of these (45% or nine) related to cancellations or waits for appointments. A further (20% or four) were due to administration errors or missing records. Only two complaints related to clinical care. Data provided indicated that all of these complaints were dealt with in an appropriate and timely manner.
- Information was available for patients and parents to access on how to make a complaint and how to access the Patient Advice and Liaison Service (PALS). Comments cards, leaflets and posters were available in all ward areas. Patients we spoke to were aware how to raise concerns or make a complaint.
- Quality outcomes boards were visible in all wards with the number of complaints made in the last month, and comments relating to things the ward could do better, such as, "waiting a long time for a bay and bed".
- Staff of all levels were able to give details of recent informal complaints and how they had resulted in changes in the service. For example, on T11, many patients had commented that the paediatric kitchen needed to be refurbished so senior staff held a fundraiser to raise the money to do so. In a set of notes in the same ward, an informal complaint about the attitude of the catering staff had been recorded by staff and resolved the same day. However, staff had little awareness of formal complaints or learning from these.
- Staff told us that findings from these would usually be shared via email and in handovers or meetings.

Are services for children and young people well-led?

Good

We rated the services for children and young people as 'Good' for well-led. This was because:

Services for children and young people

The department had a clear vision and strategy, which linked into the overall trust strategy. There was an open and transparent culture with motivated and compassionate staff who were well informed and felt they could raise concerns and were supported by senior staff and were proud to work for the trust

There was accessible and visible leadership within the department and all staff were clear of their role and responsibilities.

There were clear and effective governance arrangements and evidence of continues improvement and innovation.

Vision and strategy for this service

- Leadership team told us the vision was to develop and deliver high quality services for children and adolescents and individual as a whole and to consider the needs of the whole family. The CYP service plan was to be the best in world for the treatment and management of chronic conditions, and said they realised that there was further improvement to be made. For example the cancer services had good results in terms of survival of young people and there was effective support from the Teenage Cancer Trust (TCT) in service development. Their vision was in line with trust strategy with major focus on trust specialist areas (neurology, diabetes, cancer, endocrinology, and women's health) and desire for excellence in local provision. The NNU strategy for 2016 included family integrated care, to deliver care with support from nurses and increase long-term wellbeing.
- Senior staff we spoke with were aware of the trust vision, how it linked with departmental vision and strategies, associated challenges and plans.

Governance, risk management and quality measurement

- Each department had a clinical director with a team of clinical leads and an operational manager managing a team of matrons and charge nurses.
- There were arrangements in place for governance, risk management and quality measurement associated with the care of babies, children and young people across the trust. We found that these arrangements enabled them to measure the quality of the services they provided while noting areas needed for improvement. Staff were able to tell us about the department governance arrangements and which individuals had key lead roles and responsibilities within the department. They were clear of their own individual roles and responsibilities and where to access information from when needed.
- There were monthly divisional performance meetings, monthly safety meetings and monthly governance meetings within the units. We noted from the minutes of these meetings that complaints, incidents and emerging risk were discussed, evaluated, and monitored.
- There was a comprehensive audit programme and a number of audits were undertaken regularly in the children and neonatal services, which provided assurance that delivery of services were in line with national guidelines. The department undertook monthly audits of its compliance with safety thermometers and these ward assurance results were displayed on quality and safety boards in each area, including feedbacks from patients and visitors.
- We reviewed the paediatric and neonatal risk register, there were 20 items of which 10 were related to the children's department and 10 were related to neonate unit. Each risk had a grading depending on the severity of the risk, there were details of the lead person responsible, action taken to mitigate the risks and progress was recorded, demonstrating active management of identified risks. We saw minutes of regular staff meetings, which contained evidence of discussing and reviewing departmental risks registers

Leadership of service

- The divisional clinical director, divisional manager and head of nursing with a team of clinical leads, matrons and other leads led the paediatric and young people division. The women's health divisional manager, clinical director and head of nursing with support from NNU clinical lead, NNU matron and a general manager for maternity and neonatology, led the neonatal unit.
- We observed good leadership skills during handovers. There was clear communication with junior staff regarding their role and responsibilities for the shift. We saw consultants explaining and supporting junior staff in decision making for patient treatment. Staff said managers were approachable and they could discuss any issues with them. The senior management team were visible to staff r and were contactable if issues arose.

Services for children and young people

- The nurses and doctors we spoke with were clear about their lines of supervision. They told us how supportive the matron of children's services was., the student nurses told us that the ward team was well led by the matron and ward manager.
- Consultants and matrons we interviewed told us that overall leadership was very good and spoke highly of the senior leadership. One senior staff said "I profoundly admire the leadership style".

Culture within the service

- There was a strong team spirit from top to bottom and each member of staff said, in their opinion, their contribution was valued, which meant morale in the department was high. We observed good team working among nurses and matrons and clinical leads were very committed to support their staff.
- We saw collaborative working between the T11S and T12S staff. Junior doctors felt very well supported in their training and supervision. We saw that the medical team worked well together, with consultants being available for junior doctors to discuss patients and receive advice.
- We noted, staff within the neonatal unit were proud of the team dynamics and the willingness to change and develop their service, to meet changing demands.
- All staff we spoke with were passionate about providing empathetic care. Staff told us they enjoyed working in the department and all said everyone got on well. Staff including consultants, ward hostess and cleaners, worked supportively to meet the needs of babies, children and young people. They spoke highly about their work and were able to contribute as part of the team.

Staff and Public engagement

- Staff told us that appraisals were a useful process and development was positively encouraged. All staff told us they felt valued for the work they did. They told us that there were staff feedback events when senior staff freed up juniors to meet with the divisional manger to discuss top three worries and top three things that could be improved
- However, space for education and teaching within the neonatal unit was a concern and staff told us that they conduct their meetings in the staff coffee room, there was only one staff toilet for all staff in the unit.
- We saw paediatric and adolescent divisions' annual report included NNU staff achievements and awards they received at neonatal society.
- Patients and their families were involved via friends and family test and national patient surveys, staff told us that young children complete postcards with drawings or comments on things and their likes or dislikes. We saw one child making a card in the playroom with things they like most about their stay in the hospital. There were weekly breakfast clubs on T11 and T12S, for informal feedback from parents and their families. We saw letters of positive feedback from patients, displayed on the quality boards on T11S, T12S wards and neonatal unit.
- The department performed better than other trusts in questions relating to communication and information provision in the National Children's Day Case & Inpatient Survey 2014. Examples of improvement made as result of these feedback included, appointment of a lead paediatric nurse for the department, upgrade of the ward décor, increased presence of senior clinical decision makers and adolescents having more choice over the environment.
- Staff told us they involved young people in the interviews of a play therapist to ensure that they have the right skills and attributes to work with children and young people. Patient and families were involved in the new food menu and redesign of the ward.

Innovation, improvement and sustainability

- Staff spoke with pride about their internet websites, which were designed specifically for children and young people. The website was split into three sections; for zero to six, seven to twelve and thirteen to eighteen years, so information and style was tailored to each age group, the department worked with patients to create this website and it included a number of videos for patients.
- The department also designed a website for Children's and young people's diabetes services, which won a quality in care programme prize in 2014. The website had specific videos for pump users on how to use the equipment and had been watched over 200,000 times on YouTube.
- In 2015, London Deanery voted the NNU at ULCH, as providing the best teaching in paediatrics.

Services for children and young people

- Over the past year, in collaboration with another specialist children hospital, the NNU introduced a new treatment called Ex Utero Intrapartum Treatment Procedure (EXIT procedure) a specialized surgical procedure used to deliver and immediately stabilises babies who had complex upper airway obstruction.
- Staff told us they would be the only "Newborn Individualised Developmental Care and Assessment Programme (NIDCAP)" training centre in the UK. NIDCAP program offers an individualised and nurturing approach to the care of infants in neonatal intensive care unit (NICU) and special care nurseries (SCN). It is a relationship-based, family-centred approach that promotes the idea that infants and their families are collaborators in developing an individualized program of support to maximize physical, mental, and emotional growth and health and to improve long-term outcomes for preterm and high medical risk new born babies.
- In 2015, T11S ward developed two new cubicles to improve flow of patients from emergency department to the ward.

Outpatients and diagnostic imaging

Safe	Good
Effective	Not sufficient evidence to rate
Caring	Good
Responsive	Good
Well-led	Good
Overall	Good

Information about the service

University College London Hospitals NHS Foundation Trust provides outpatient services from nine locations registered with us. This report relates only to the University College Hospital & Elizabeth Garrett Anderson Wing as we did not carry out inspection of the remaining locations. There were over 664,943 first and follow-up outpatients appointments booked at the hospital between September 2014 and August 2015. Clinics held in outpatients' areas included neurology, rheumatology, thoracic medicine, cardiology, obstetrics and gynaecology, physiotherapy, trauma and orthopaedics, oncology, haematology and gastroenterology among others. Obstetrics and physiotherapy clinics were among the most attended clinics in 2014/2015, followed by gynaecology, orthopaedics, clinical and medical oncology and anticoagulation clinics.

Services within outpatients was managed within individual clinical divisions. Nursing staff supporting the delivery of general outpatient services were managed within the medical specialties division. The imaging department occupied a number of areas within the hospital and included magnetic resonance imaging (MRI) and computerised tomography (CT) scanning, ultrasound, and x-ray areas.

We visited the general outpatients, oncology, orthopaedics, radiology, women and children's outpatient clinics and therapies department. We also visited the medical records department and a call centre where patients' appointments were booked.

We spoke with 39 patients and some of their relatives or carers. In addition, we spoke with 84 members of staff, including managers, doctors, nurses, radiographers and radiologists, administrators, receptionists and members of the health records team.

We observed care and treatment and looked at care records. Before our inspection, we reviewed performance information from, and about, the hospital and we requested additional information from the trust after our inspection.

Outpatients and diagnostic imaging

Summary of findings

Outpatients and diagnostic imaging services provided at the hospital were safe, caring, responsive and well managed. Since January 2015 the trust had continuously met the 18 weeks referral to treatment targets and performed better that the England average through the year. Although the trust met national targets related to cancer treatment at the time of inspection, they performed worse than the England average in 2014 and 2015.The hospital had effective systems for monitoring service quality and risks associated with its delivery. The hospital was able to assess and respond to patient' risk accurately and had effective systems for monitoring patient referrals and cancellations to avoid treatment delays. There was good staff awareness and care for patients living with dementia. We observed strong local and senior leadership; managers were aware of issues faced by their departments and able to oversee outpatients' activity at the hospital. Patients' treatment was well planned, which allowed preventing delays to treatment and improving patients' experience. Information, including patients' medical records, was easily available. Patients were treated with compassion, dignity and respect; they were fully involved in decisions about their care and treatment.

We rated safety in outpatients and diagnostic imaging as good because:

- Incidents related to safeguarding were appropriately recorded and actions were taken to address them.
- There were effective systems which allowed minimise risk through monitoring patients' referral to treatment times and cancellations.
- There were systems for reporting incidents and raising concerns. Outcomes from these were shared with staff and used for shared learning.
- Records were stored securely.
- The environment was clean and hygienic and the department was staffed adequately in order to run all of the outpatient and diagnostic imaging services.

We do not rate effectiveness, as our policy, in outpatients and diagnostic imaging owing to the difficulty in obtaining evidence to support a definitive rating.

We rated caring in outpatients and diagnostic imaging as good because:

- Patients were treated with dignity and their privacy was respected. Patients provided positive feedback through NHS Friends and Family Test.
- Patients were aware of their care plans and understood choices of treatment offered to them.
- Staff were able to recognise where patients' were distressed and act appropriately.
- Patients and their relatives could access services which helped them with overcoming emotional difficulties related to illness or bereavement.

We rated responsiveness of the outpatient and diagnostic imaging service as good. This was because:

- The trust consistently performed better than the England average for referral to treatment (RTT) non-admitted and incomplete pathways in 2015.
- There was a system to monitor repeat cancelations of appointments by the hospital and by the patient which helped to avoid treatment delays linked to multiple cancelations. Patients' average waiting time, from their arrival at the clinic to their appointment, was less than 30 minutes.
- We also noted there were effective systems for managing non-urgent referrals.
- Although it was not mandatory, most staff completed dementia awareness training. Staff ensured patients who lived with dementia or who had learning disability were seen quickly to minimise the possibility of distress to them.
- Patient complaints were addressed appropriately and information on how to complain was easily accessible to them.

However:

Outpatients and diagnostic imaging

- The trust had performed worse than the England average in 2014- 2015 for percentage of people seen by specialist within two weeks from the urgent referral made by the GP. This was just around 2% below the England average.
- The trust also performed worse than the England average in relation to 31 days from diagnosis to first definitive treatment target, and 62 days target (from urgent GP referral to treatment).

We rated well-led in outpatients and diagnostic imaging as good because:

- There were systems which allowed effective performance monitoring. Risks were listed on local risk registers which were up to date and reviewed regularly.
- There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging departments.
- We observed that staff worked well as a team supporting one another. Staff told us they felt able to raise concerns and discuss issues with the managers of the department.

Are outpatient and diagnostic imaging services safe?

Good

We rated safety at outpatients and diagnostic imaging services provided at the hospital as good. There were effective systems which allowed minimise risk through monitoring patients' referral to treatment times and cancellations. There were systems for reporting incidents and raising concerns. Outcomes from these were shared with staff and used for shared learning. Records were stored securely. The environment was clean and hygienic and the department was staffed adequately in order to run all of the outpatient and diagnostic imaging services. Incidents related to safeguarding were appropriately recorded and actions were taken to address them.

Incidents

- Staff told us they were confident in raising concerns with their line managers. Themes from incidents were discussed at quality and risk meetings and team meetings.
- One serious incident was reported between October 2014 and September 2015 for the outpatients and diagnostic imaging services provided by the trust through the strategic executive information system (STEIS). It related to faulty equipment in nuclear medicine department which resulted with patient being trapped between camera heads. The incident was adequately investigated and root cause analysis was completed with learning points identified. It was caused by deviation from the operational procedure. Investigation findings were shared with manufacturer to alert them to the equipment safety issues and standard operating procedure was updated to include best practice elements
- There were no never events related to delivering outpatient services at the hospital in 2014 or 2015. Never events are serious, wholly preventable patient safety incident that has the potential to cause serious patient harm or death, has occurred in the past, and is easily recognisable and clearly defined. Although each

never event type has the potential to cause serious potential harm or death, harm is not required to have occurred for an incident to be categorized as a never event.

- 1,041 incidents relating to various outpatient departments and diagnostic imaging were reported between February 2015 and January 2016 across the trust. There were six incidents were patients came to moderate harm (0.6%) and 162 allocated to the low harm category (16%), other incidents were classified as 'no harm'. Half of all incidents were reported within 30 days from the time of occurrence, 36% took between 31 and 90 days to report and additional 174 incidents (17%) took over 90 days. We observed that from September 2015 most of incidents were reported within 60 days with majority of December 2015 and January 2016 incidents reported within 30 days. We also noted a downward trend in the number of incidents reported per month. Incidents related to clinical assessment were the most prevalent type (27%). One of these resulted in moderate harm and the others were all low or no harm. Documentation-related incidents were the second most prevalent type (20%). All of these were low or no harm.
- Staff told us they were encouraged to report incidents and received direct feedback from their line managers. They had access to an online reporting form and told us they felt confident using it. Staff were able to give us examples of where practice had changed as a result of incident reporting. We were told all incidents were investigated using a root cause analysis tool, taken into account the contributory factors which may have contributed to the incident.
- Staff were aware of actions they should take in cases were 'reportable patient safety incident' occurred and assured us they were open and transparent. Divisional quality and safety board meetings, which took place monthly, involved discussions related to duty of candour to ensure staff, took appropriate actions and patients were informed about the incident, provided with support, truthful information and an apology when things went wrong. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The chemotherapy quality management team said there were four extravasations in chemotherapy day-care since 2013. Extravasation is the process by which fluid or drug accidentally leaks into the surrounding tissue surrounding the intravenous or intra-arterial administration site.
- Staff participated on daily departmental huddles introduced in 2015. They told us these meetings were used to discuss incidents and learning from them and that they felt it improved communication across departments.

Cleanliness, infection control and hygiene

- Clinical areas we visited appeared clean, and we saw staff washing their hands using hand gel between treating patients. Toilet facilities and waiting areas were also clean in all areas we visited. Some of the equipment was labelled with the green stickers to show that they were clean and ready to use, however, use of these method was inconsistent. Personal protective equipment, such as gloves and aprons, was available for staff use in all areas where it was necessary.
- Staff working in the outpatient areas had a good understanding of their responsibilities in relation to cleaning and infection prevention and control.
- We observed that hand sanitisers were easily accessible to staff and patients and others visiting the hospital. They were routinely placed near an exit or entrance to the area, encouraging people to sanitise their hands there and then.
- Results from the 2015 Patient-Led Assessments of the Care Environment (PLACE) programme indicated that the outpatients' areas were mostly clean achieving score of 99% which was in line of the England average (98%).These self-assessments are undertaken by teams of NHS and independent health care providers, and include at least 50 per cent members of the public.
- There were members of staff allocated to monitor waste compliance and contracts with external providers responsible for clinical and non-clinical waste management. There was a team responsible for auditing if waste was managed appropriately and audits were carried out monthly. They checked if waste was stored appropriately, labelled and if traceable tags were used. They also checked if staff were trained in handling and correct disposal of waste, wore protective clothing whilst handling it, and if waste was transported and disposed of appropriately.

- Environmental monitoring officers were responsible for 'facilities environment walk rounds' which helped to ensure adherence to infection control standards.

Environment and equipment

- All equipment we looked at was tested and in date and appeared safe to be used.
- However, there was lack of oversight in relation to resuscitation equipment checks. In some areas it was checked daily, weekly and monthly in others it was more sporadic and checks did not take place regularly. Where checks were carried out they were documented.
- Medication boxes on the resuscitation trollies were sealed, adequately equipped and in date. However, we noted that staff did not check regularly whether all required equipment was available.
- Equipment used in the diagnostic imaging department had been checked regularly and serviced in line with published guidance.
- Results from the 2015 Patient-Led Assessments of the Care Environment (PLACE) programme indicated that outpatients' areas were in good condition and were maintained well. The hospital achieved 97% score which was better than the England average (91%).

Medicines

- Medicines were kept in a locked medicines cupboard, and those that require refrigeration were kept in a fridge. Fridge temperatures were checked to ensure medicines were stored at correct temperatures.
- Staff told us they were trained in medicines management and were aware of their responsibility in the safe administration of medicines.
- All emergency medication and emergency equipment and resuscitation trolleys were available. Some staff we spoke to were not aware which emergency medication was available to them and how to use it. They told us they would call the internal hospital's emergency number should there be a need to use it.
- The pharmacy service operated with a turnaround time target of 25 minutes for outpatient prescriptions. Data presented by the trust demonstrated that they normally met this standard.
- Pharmacists routinely took part in all outpatient chemotherapy clinics and gave extra information to patients about their therapy.
- The aseptic dispensing unit was open on Sundays to prepare chemotherapy ready for Monday morning.
- Medicines errors and incidents were reported quarterly. A multidisciplinary team of the medication safety committee reviewed reported medicines incidents, identified themes and trends and, where appropriate, any actions to be taken in response to incidents. Learning from incidents was shared with all staff via a monthly newsletter.

Records

- Clinical records kept were a combination of electronic records and paper records. Paper records, currently in use in the outpatient department were stored securely behind the reception desk. Electronic records were available only to authorised people. Computers and computer systems used by the hospital were password protected. Individual log in details were used by all members of staff including those who worked part-time and temporary staff.
- We observed that patients records were occasionally left unattended in open trolleys outside of consulting rooms in general outpatients areas.
- Patients' paper records, when not needed for access, were stored at another location, managed by an external provider, and delivered by courier approximately three times per day. The medical record team received records well in advance and were preparing notes three days before the clinic took place. Nurses and doctors across all clinics told us where occasionally patient records were not delivered before the day of the clinic they could be still delivered on the day of it. Doctors told us they did not cancel appointments if notes were not delivered and there were no delays to patients' appointments linked to unavailability medical records. Some of the departments, for example physiotherapy and chemotherapy, stored their patients' notes on site and managed them internally.
- Patients' records were comprehensive and clearly described patients' treatment plans, medical histories and any relevant risk assessments.
- Records for resuscitation trollies' checks were not maintained. For example, within the imaging department checks were not completed in September 2015. There were also gaps for most of the months of 2015 in physiotherapy and fracture clinic areas as well as most of the areas of the cancer centre. We noted that all trollies checked by us were appropriately equipped.

Although audits, which indicated poor records quality, were undertaken monthly no actions were taken to ensure improvement. In 2015 no checks were recorded for outpatient areas for six months.

Safeguarding

- The hospital had policies for safeguarding children and vulnerable adults. Staff we spoke with were aware of the policies and procedures with regard to safeguarding, and they knew how to raise a safeguarding alert.
- There was a named doctor, nurse, midwife and a general manager with responsibility of overseeing issues related to child safeguarding. They met monthly with the trust lead and quarterly with trust wide safeguarding committee. The trust chief nurse was 'the responsible director' for adults safeguarding. There were also a named safeguarding adults lead, learning disability nurse, domestic violence officer, and dementia lead at the hospital.
- The trust required a minimum of 90% of all staff to have up to date training in safeguarding. Both children and adults trainings at level 1 and level 2 were provided online with level 3 delivered in a classroom environment. Staff were required to refresh the training every three years.
- The trust told us that a matron responsible for imaging and gastrointestinal services completed level 3 adults safeguarding training.We were also told that other staff working within the imaging department did not require it. None of medical staff had been trained at level 3 in child safeguarding. They had completed children level 1 and 2 trainings. Only 63% of medical staff working within the same department completed adults level 2 training. All of them had up to date level 1 training, the hospital did not meet the requirement, which requires all staff working with children to have level 3 children safeguarding training.

Mandatory training

- All staff were required to complete mandatory training in health and safety, care of the back, manual handling, fire safety awareness, infection control, information governance, basic life support, risk awareness, treating people with respect, medicines management conflict resolution and management, and hand hygiene . Most of the courses were completed every two years with others every three years and some once only.
- The trust had set a target of 90% for mandatory and statutory training completion. Records indicated that 87% of staff working within cancer service completed their training. Similarly surgical specialties were slightly below the required target with 88% completion rate. 91% of all staff working in diagnostic imaging and outpatients departments had completed mandatory trainings. Medical specialties also achieved the target with 94% compliance rate.
- There was a low adults basic life support training compliance rate, among medical staff working in imaging department (50%), surgical specialties (63%) and those working within medical specialties (77%).
- 92% of nursing and midwifery staff working within all outpatients specialties and diagnostic imaging completed mandatory training. This rate was also above the target for healthcare scientists (96%), allied health professionals (94%) and additional clinical services and other scientific staff and technicians (92%). However we observed below the target rates among doctors (79%), estates and ancillary staff (88%), and administrative and clerical staff (88%).

Assessing and responding to patient risk

- Various rapid access clinics and walk in services were available, such as chest pain clinic, or rapid access falls clinic. This helped to prevent delays to patients' treatment and minimise risk of deterioration. There was an older person's assessment unit based at the hospital which offered range of services including comprehensive physiotherapy and occupational therapy assessments.
- Many outpatients' clinics offered clinical support over the telephone; it was provided by clinical nurse specialists and allowed staff to respond to patients' urgent queries. For example, patient who received chemotherapy but were not admitted to the hospital had direct access to specialist nurses working on the oncology ward. They could also visit the ward out of hours if they felt that their health was deteriorating and they required medical assistance.
- Cancer services were structured to allow access within the two weeks target. There was a system used for monitoring patients' referral to treatment times to identify those who had waited for a prolonged period of time, or those who experience multiple cancellations of their appointments. It was used effectively and staff

were aware of how they performed in relation to waiting times. Diagnostic imaging services reported quickly on diagnosis to avoid delays in treatment with most of reports being produced on the same day.

- There was emergency equipment available to respond in the event of emergency. The equipment was easily accessible.
- Staff were aware of local rules for checking that the patient consent including checking that all female patients between the ages of 12-55 had signed the relevant section of the consent form relating to pregnancy status. Local rules stated that operators must not expose any female patient between 12-55 years old who did not sign the form. If the patient was pregnant and required exposure, for example within the radiotherapy department, staff were advised to contact the consultant clinical oncologist to confirm treatment options and risks involved.
- Operation of digital imaging equipment, when initiating the exposure, ensured that the patient was correctly identified to prevent unnecessary exposure and potential incidents.

Nursing staffing

- Nurses told us there was a sufficient number of staff in post to run all of the scheduled clinics and extra evening and weekend clinics when required. The sickness rate for the outpatient departments was 1%, it was better than the hospital average 2.8% (2014/2015). Similarly it was low within the nuclear medicine and medical physics departments (recorded at 0%), ophthalmology (0%), general surgery, gynaecology, haematology, and infection outpatients (1%). It was slightly worse among the medical specialties staff (2.4%), oncology directorate (2.8%)and the radiology department (4.6%).
- Overall there was a good level of retention of staff within radiotherapy directorate, medical physics, pathology, and general surgery and infection outpatients with turnover rate of 0% (2014/2015). Staff turnover rate for medical specialties (27%), oncology (23%) and gynaecology (18%), was worse than the hospital average 18%. The worse rate, above 60%, was recorded among nursing staff working in ophthalmology, haematology and nuclear medicine. We noted that these were small teams often affected by a single staff member leaving. Trauma and orthopaedics department also noted worse that the hospital average turnover rate of 29% with more than 19 members of the team leaving in 2014/2015.
- The average vacancy rate for the trust was 8.8%. The trust recorded much better rate for general surgery department, haematology and ophthalmology (0%). It was also good among the nursing staff working in the general outpatient department (3.1%), oncology services (4.4%) and trauma and orthopaedics (6.9%). The vacancy rate among staff working within the radiology (11%) and radiotherapy departments (12%) was worse that the trust's average. There was a high number of vacant posts held within the nuclear medicine department (60%), and one vacancy within the medical physics which accounted for 100% of total nursing staff. Vacancies were covered by temporary staff.
- The trust reported average rate of temporary staff use of 14% between December 2015 and March 2015. The record indicated it was higher within the outpatient department (19%) and lower for radiology (11%) and therapies outpatients (3.5%). Temporary staff were employed within the nuclear medicine.

Medical staffing

- Overall, we observed there were sufficient numbers of doctors to run all scheduled outpatient clinics. The vacancy rate among medical staff for the trust was at 6.16%. There were nine vacancies within the therapies outpatients department (42%) and 3.5 vacant posts for nuclear medicine (26%). Other specialties where the vacancy rate was higher than the trust average were radiology (16%), oncology (12%), gynaecology (10%) and trauma and orthopaedics (9%). There were no vacancies within general surgery, radiotherapy, ophthalmology and medical specialties.
- The turnover rate among medical staff at the trust was 7.2%. It was better than the hospital average within general surgery, radiotherapy, pathology, trauma and orthopaedics, nuclear medicine and outpatient therapies.
- The sickness levels among medical and dental staff across outpatient specialties were below 0.5%, which was better than the hospital average (3%).
- There were sufficient number of radiographers, radiologist and other staff supporting delivery of diagnostic imaging services to meet patients' needs.

Outpatients and diagnostic imaging

Major incident awareness

- There were plans drawn up for the hospital in May 2015 to ensure business continuity and that essential services were not disrupted as a consequence of emergencies and when internal incidents were declared. They were informed by national guidance such as the NHS Commissioning Board's 'command and control' and 'business continuity management framework'. The internal incident management procedure and the emergency preparedness, resilience and response policy were generic and did not specify specific roles for staff working within outpatients or diagnostic imaging departments.
- There was a site control room located on the ground floor with alternative locations identified in nearby buildings. These were equipped with site plans and equipment to ensure effective communication and gathering up to date information.
- The trust did not provide us with information on how many of the staff working within outpatients and diagnostic imaging received major incident awareness training.
- Staff used dosimeters to ensure unintended exposure was detected. Standard preventive measures were implemented as instructed by relevant regulations related to ionizing radiation and to radioactive material. Heads of departments monitored radiation safety in their departments and reported results of that monitoring to the radiation protection advisers and radioactive waste advisers.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

We did not have sufficient evidence to rate effectiveness of the outpatients and diagnostic imaging services. The hospital followed National Institutes for Care Excellence (NICE) guidelines and other evidence based practice when providing treatment. Many clinics had multi-disciplinary (MDT) meetings and staff reported overall good MDT engagement which allowed for analysis of individual treatment options and for knowledge sharing. Staff were competent and knowledgeable. Managers provided staff with development opportunities and appraised them annually to ensure they continued to develop their practice. There were protocols in place for obtaining consent before medical treatment was given and staff were aware of it. We also noted that most of the results of the national cancer patient experience survey 2014 were worse than the national average.

Evidence-based care and treatment

- The radiation safety policy from June 2013, although containing relevant and mostly up to date information, was due to be reviewed every 2 years. At the time of our inspection it had not been reviewed within the required timescale. It was written by the head of medical physics and the medical director for cancer and surgery board. It took into consideration relevant legislation, regulations and guidance such as The Ionizing Radiations Regulations 1999; The Ionizing Radiation (Medical Exposure) Regulations 2000 (IRMER); Radioactive Substances Act Guidance issued by the Environment Agency; The Ionizing Radiation (Medical Exposure) Regulations (2000) Guidance and Good Practice issued by the Department of Health; and guidance published by Health and Safety Executive.
- Staff working within radiotherapy department were aware if IRMER procedures which described role specific duties and local rules. They signed a raining record to indicate that they understood their duties and responsibilities related to these regulations.
- There were patient access policies and protocols, guided by Department of Health guidance, for urgent and non-urgent referrals. These set out the overall expectations of the trust and local commissioners on the management of referrals and admissions into and within the organisation. It also set out the responsibilities of staff and administration processes that should be followed to prevent delays and ensure care was delivered in line with clinical guidance.
- British Society of Gastroenterology and NICE guidelines for colonoscopy surveillance for prevention of colorectal cancer in people with ulcerative colitis, Crohn's disease or adenomas were implemented at the hospital.
- The trust assured us that NICE guidelines for management of chronic obstructive pulmonary disease (COPD) were implemented. The trust participated in the

national COPD audit in 2014 and achieved Commissioning for Quality and Innovation payment framework goals in 2012/13 and 2013/14 which related to COPD.

- The main assurance to ensure NICE guidelines for management of type 2 diabetes were followed were obtained is through discussions in multidisciplinary meeting. The trust circulated guidelines to all consultants, associate specialists, registrars and diabetes nurses. There was a database which allowed clinicians to audit the level of glycaemic control and cholesterol. The trust was working on developing database which would allow participation in the national audit. In April 2015 the hospital audited diabetes letters which were sent out to patients and their GPs. In 84% of patients diagnosis was correct but medication was wrongly recorded; in 32% diabetes medication regime and 53% other medication. Eye data was present in only 47% and foot data in 68%. Glycated haemoglobin's levels were recorded in most (HbA1c; 94%) as was albumin creatinine ratio (ACR; 84%) but records of liver function tests were found in very few.

Pain relief

- Results of the national cancer patient experience survey 2014 suggested that 84% of cancer patients felt staff did everything to help control pain at all times (day patients / outpatients). These results were slightly worse than the national average of 88%. 71% of patients thought staff did everything to control side effects of radiotherapy and 76% answered the same question in relation to side effects of chemotherapy. This was worse than the national average of 78% and 81% and worse than the trust's performance from previous years. The trust was listed among the 20% worse performing trusts for the question related to side effects of the chemotherapy treatment. Clinical lead assured us that the cancer services improved since the survey results were published. They provided staff with additional training, reviewed information available to patients and improved access to clinical nurse specialist. They involved all relevant stakeholders across the trust, including cancer and surgery board, nursing and midwifery board, patient experience committee, matrons committee and the cancer clinical steering group.
- Patients said they had access to pain relief when required. Doctors could refer them to the pain management centre managed by the trust and located at the National Hospital for Neurology and Neurosurgery. The service was designed to support people with longstanding pain. It was a multi professional service made up of doctors, nurses, physiotherapists and psychologists. They offered systemic drug treatment, intravenous drug infusions, peripheral and central nerve blocks, radio frequency lesioning and spinal implants.

Patient outcomes

- The hospital collected cancer staging data (data collected on identifying the severity of cancer) for all patients diagnosed with cancer. However, they did not benchmark themselves against other trusts to establish how they perform in relation to cancer staging as the data collected by the hospital and the electronic database used did not allow reporting to the national registries fully. Staging data was submitted as part of the cancer services outcomes dataset (COSD) managed by the National Cancer Intelligence Network on a monthly basis to the cancer registry. In 2015 the staging values were recorded in 77% of all cases, the trust had compared it to a commissioning intentions target of 75%.
- The follow-up outpatient appointment to new appointment rate for the trust as a whole (1:4) was consistently above the England average (1:2.3) between September 2014 and August 2015. The rate for the hospital (excluding the cancer centre) was 1:4.8.
- Hospital records for March 2015 to February 2016 indicated that lowest follow- up to new appointment ratio was recorded for infection (1:1), neonates and breast (1:1.2), retained cardiology clinics (1:1.3), allergy (1:1.4), and gynaecology (1:1.5). Other specialties with rates lower than the England average included general paediatrics, Sleep service, care of elderly, dermatology and gastrointestinal clinics.
- Clinics with higher than the 1:2.3 ratio included: head and neck, clinical pharmacology, therapies and rehabilitation, as well as other clinics which supported patient with long term medical conditions management (i.e. nephrology, diabetes and endocrinology, obesity

services, rheumatology) . The highest follow-up to new appointment ratio was noted for haematology (1:15.3), paediatric diabetes and children and young people cancer clinics (1:24.7), and oncology (1:8.7).

- Most of the results of the national cancer patient experience survey 2014 were worse than the national average (60 out of 70). For 16 questions the trust performed worse than most of trusts taking part in the survey and was at the bottom 20% of all trusts. The trust provided staff with additional training, reviewed information available to patients and improved access to clinical nurse specialist since the results were published. There were plans for 2016 to provide advanced communication skills training for senior members of the team working in cancer care. Clinicians told us clinics schedules were reviewed to minimize delays and ensure maximum utilization of consulting rooms.
- For seven questions the trust scored better than the average and in three cases results were equal to the national average. The survey indicated that 77% of patients thought they were seen as soon as necessary. The trust was among the 20% worst performing trusts in relation to this question.
- We noted that 92% of patients were given a name of a clinical nurse specialist in charge of their care, which was better than during previous years and the only measure were the trust scored at the top 20% result for all trust.
- There was no audit due to the low number of extravasations. Senior nurse planned to undertake extravasation of intravenously administered chemotherapy drugs audit in November 2016.
- Where we saw evidence of poor audit results we did not see improvement action plans in place.

Competent staff

- Staff working in outpatients areas were appraised annually. Records indicated 100% appraisal completion rate amongst nurses and additional clinical services staff and 95% rate for administrative and clerical staff. Similarly good rates, between 92% and 100%, were recorded for staff working within the radiology, radiotherapies, medical physics, nuclear medicine, infection and therapies outpatients. Lower rates were noted for allied health professional working in nuclear medicine (83%) and administrative and clerical staff working in infection outpatients (86%). Overall the appraisal rate for outpatients and diagnostic imaging was in most cases better than the trust average of 92%.
- The clinical governance reports indicated that doctors' revalidation was coordinated by a named individual within the trust. The trust had been recognised for its contribution to teaching and trainee doctors reported high levels of satisfaction with the opportunities and experiences afforded to them.

Multidisciplinary working

- Nursing staff reported having excellent support from medical staff and a good working rapport with their colleagues. Communications and teamwork was evident in all interaction observed by us where multi-disciplinary staff engaged in discussion related to patient care and treatment needs.
- Many clinics had multi-disciplinary (MDT) meetings, particularly the cancer related specialties, where the team agreed and planned the care for patients and decided which clinician would be seeing the patient in clinic to explain the plan to them. For example the breast team organised weekly MDT meetings attended by members of women's health and cancer services divisions. It included surgeons, radiologists, pathologists, medical and clinical oncologists, breast and oncology specialist nurses (CNSs), advance nurse practitioner and MDT coordinator.
- Patients meeting the criteria for pulmonary rehabilitation were referred to local community COPD teams in Camden, Islington and Westminster. The hospital worked closely with these teams with weekly multidisciplinary meetings (MDT) with the Camden and Islington community teams.

Seven-day services

- Most of the outpatient clinics operated from Monday to Friday. They were scheduled to run from 8.30am to 6pm. Some additional clinics were run at the weekends; staff were monitoring how these were received by patients. Staff said patients were happy to come at weekends and that the number of patients failing to keep appointments appeared to be low.
- The x-ray and other clinical imaging services were available to patients referred by GPs Monday and

Wednesday, 9am to 6.45pm and 8.30am to 4.45pm on other weekdays. There were also facilities designed to provide imaging services for inpatient department, available seven days a week.

- Blood testing services were available for patients attending outpatient clinics on the same day. There was a walk in service available at the local South Camden Centre for Health; it was open 8am to 5pm Monday to Friday.

Access to information

- Clinicians used both paper and electronic patients' records. All of them said they had easy access to electronic records system. The system allowed for storing all clinic and external letters and diagnostic information about patients. Discharge summaries were also available on it. The trust told us the percentage of patients seen in outpatients without the full medical record being available, where paper records were required, was low (1.4%; patients being seen with temporary case notes files). We were unable to ascertain if this figure was across all outpatient clinics.Urgent request for medical records could be made and delivered to the hospital within an hour from the external storage facility.
- The hospital was working towards full digitisation of patient paper records to ensure immediate availability at the 'point of care', consistency across departments and reduction in incidents where records were unavailable, misplaced, or damaged. A business plan prepared by the director of digital services and their team in January 2016 and was waiting to be signed off by the trust's board.
- The medical records team had clearly defined priorities and quality indicators which they monitored performance against to ensure effective operation. Performance of the external company involved in medical records management was also closely defined by the service level agreement and monitored effectively through monthly meetings with the company. The contract allowed for any change and potential reduction in service as a result of full digitalisation of paper records in the future.
- Some of the individual clinics and other trust's locations managed their own medical records system and employed own staff to look after it. This included therapies and the cancer centre outpatients and chemotherapy units. There was a 'records and information governance group' tasked with centralisation of the management of medical records and planned to unify processes and bring all staff under medical records structures by April 2016.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that there was a policy and protocols in place for obtaining consent before medical treatment was given.
- Nurses and doctors were clear which procedures they would follow should patient's capacity to consent be in question. Staff spoke about a need for a mental capacity assessment to take place and said they were guided by procedures used for reaching 'best interest' decision prior to treatment being offered or the procedure being performed.

Are outpatient and diagnostic imaging services caring?

Good

Patients were treated with dignity and their privacy was respected. Patients provided positive feedback through NHS Friends and Family Test. They told us they were aware of their care plans and understood choices of treatment offered to them. Staff were able to recognise where patients' were distressed and act appropriately. Patients and their relatives could access services which helped them with overcoming emotional difficulties related to illness or bereavement.

Compassionate Care

- Patients told us they privacy and dignity was respected their consultations took place in private rooms.
- We observed patients being treated with dignity and respect by staff. Reception staff directed patients to waiting areas when required and informed them of the waiting time.
- Results from the 2015 Patient-Led Assessments of the Care Environment (PLACE) programme indicated that patients' privacy, dignity and wellbeing were maintained within outpatients' areas. The hospital achieved scores

of 92% and 97% which was better that the England average (87%).These self-assessments are undertaken by teams of NHS and independent health care providers, and include at least 50 per cent members of the public.

- Staff, when made comments about their work colleagues, said they were always "smiling and saying hello", and were "nice and helpful to patients" they also thought "everyone handled stressful days with a smile".
- 83% of patients taking part in the national cancer patient experience survey 2014 reported that doctors did not talk in front of them 'as if they were not there'. The trust slightly improved this result when compared with the previous year and performed in line with the national average in relation to this measure. However, for similar question related to clinical nurse specialists talking in front of patients 'as if they were not there' the trust scored at the bottom 20% of all trusts with 81% (national average of 85%)
- The national cancer patient experience survey 2014 also indicated that 79% of patient felt they were told sensitively that they had cancer; this was lower than the national average of 84%. 90% thought clinical nurse specialist definitely listened carefully the last time they spoke to them, which was in line with the national average. The same number of patients (90%) received understandable answers to important questions all/most of the time from them, which was also in line with the national average. The trust provided staff with additional communication training which included training for senior clinicians. They also improved patients access to the Macmillan Cancer Centre to ensure there was no delays.
- The hospital started using the NHS Friends and Family Test in October 2014 as required by NHS England. This is a single question survey asking patients whether they would recommend the department to their friends and family. We have reviewed data available for the trust which indicated that 94% would recommend the outpatient clinics to their friends and family and only 1% would not. This was slightly better than the England average of 92% and 1% and better than the London average of 93% and 3%. However, we observed a low response rate, at 2.5%, when compared with the London average (4.6%). It was also much lower than the England average 6.3%. The hospital used varied methods for collecting 'friend and family' feedback, which included; electronic tablets in individual clinics, a postcard given to patient after their clinic, online survey and in minority of cases a telephone survey.

Understanding and involvement of patients and those close to them

- Results of the national cancer patient experience survey 2014 suggested that 69% of patients felt involved in decisions about their care and treatment, and 81% were given written information regarding potential side effects of their treatment, it was slightly lower than the national average for these questions (71% and 82% respectively). 85% reported that staff gave a complete explanation of what would be done prior to surgery and 71% were given written information, these results were also slightly lower than the national average (88% and 76%). The survey also indicated that in 72% of cases doctors had explained test results in an understandable way, and in 85% of cases provided patients with written information about tests. These results were lower than the national average of 78% and 87%.
- Patients told us they were aware of their care plans and understood choices of treatment offered to them. They said that if they had any queries regarding appointments they would contact individual clinics or medical secretaries.

Emotional support

- Staff were able to recognise where patients' were distressed and act appropriately. For example on one occasion where a patient was unhappy after leaving doctors room nurse took them to another room to discuss their concerns and offer additional guidance. On another occasion a nurse helped patient with obtaining their medication by taking their prescription down to the pharmacy for them
- As indicated by the national cancer patient experience survey 2014, 84% of patients said the hospital staff gave information about support groups. This result was slightly better than the national average. Answers to questions related to the hospital providing information about the impact cancer could have on work or education, financial help and free prescriptions were slightly worse than the average.
- Patients diagnosed with life limiting illness had access to integrated palliative care team which worked across

boroughs and hospitals. The team could offer specialist advice for managing pain and other symptoms, such as nausea, vomiting and fatigue, and provide social, spiritual and emotional support.

- There was a lymphoedema service that provided assessment, diagnosis, conservative treatment and management of cancer related lymphoedema. The service was clinically-led by consultant nurse in cancer and supportive care supported by nurse specialists and a lymphoedema specialist physiotherapist.
- Patients could also access the Macmillan Support and Information Service located within the cancer centre. It offered a range of supportive care services for those affected by cancer and red cell conditions. The team consisted of welfare and benefit advisor, psychologists and emotional care team, volunteers, dietician, complementary therapist, and wig and scarf tying adviser among others.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsiveness of the outpatient and diagnostic imaging service as good. This was because:

- The trust consistently performed better than the England average for referral to treatment (RTT) non-admitted and incomplete pathways in 2015.
- There was a system to monitor repeat cancelations of appointments by the hospital and by the patient which helped to avoid treatment delays linked to multiple cancelations. Patients' average waiting time, from their arrival at the clinic to their appointment, was less than 30 minutes.
- We also noted there were effective systems for managing non-urgent referrals.
- Although it was not mandatory, most staff completed dementia awareness training. Staff ensured patients who lived with dementia or who had learning disability were seen quickly to minimise the possibility of distress to them.
- Patient complaints were addressed appropriately and information on how to complain was easily accessible to them.

However:

- The trust had performed worse than the England average in 2014- 2015 for percentage of people seen by specialist within two weeks from the urgent referral made by the GP. This was just around 2% below the England average.
- The trust also performed worse than the England average in relation to 31 days from diagnosis to first definitive treatment target, and 62 days target (from urgent GP referral to treatment).

Service planning and delivery to meet the needs of local people

- The department ran five one stop clinics for medical specialties which included dermatology which allowed for a biopsy to be taken on first visit; respiratory clinic which involved a computer tomography scan results of which were discussed with a doctor on the same day; rapid chest pain clinic; thalassemia clinic; cardio oncology clinic; and rapid access multidisciplinary elderly medicine clinics.
- There were no CQUIN targets set for the hospital for 2015/2016. These are local population specific targets set by the commissioning group related to outpatients or diagnostic imaging.
- There was a system to monitor repeat cancelations of appointments by the hospital and by the patient. This allowed monitoring clinical risk related to treatment delays to individual patients who experienced cancellations.
- The hospital provided a non-emergency patient transport service to patients eligible under Department of Health criteria. The hospital transport service worked within a 95% target, set by the trust, for patients to arrive no earlier than 45 minutes before their appointment time and no later than 15 minutes after it. After a patient's appointment they aimed to offer transport within 60 minutes (95%). The hospital performed mostly above the required 95% across 2015/2016.
- There was sufficient seating available to patients in general outpatients areas, diagnostic imaging areas and the cancer centre. Patients had access to water and could purchase other refreshments and snacks at the hospital.

Outpatients and diagnostic imaging

Access and flow

- The trust consistently performed better than the England average for referral to treatment (RTT) non-admitted and incomplete pathways in 2015. The trust consistently achieved 18 weeks RTT of 95% for non-admitted and 92% for incomplete pathways in 2015.
- The trust performed worse that the England average, of less than 2 weeks, for diagnostic waiting times in 2014 and 2015. Although the trust achieved overall six weeks in 2015 records indicated that some patients were required to wait for up to eleven weeks in January 2015, and for longer than six weeks between February and April 2015.
- In September 2015 diagnostics waiting times were reduced to three weeks but they then increased back to six weeks by the end of the year. Although there were sufficient staff available they were restricted by availability of equipment such as magnetic resonance imaging (MRI). The trust reviewed hospital's needs and planned to purchase additional equipment to reduce waiting times.
- Cardiology patients waited on average five weeks for echocardiography and Holter electrocardiograph, two weeks for ambulatory blood pressure monitoring device or an exercise test.The minimum notice periods of six weeks for outpatient hospital cancellations were prescribed by the trust's access policy. The policy stated that patients should not be cancelled more than once and that clinic cancellation with less than six weeks' notice could only be authorised by the divisional manager or divisional clinical director. Most outpatient departments operated a form that needed to be completed if hospital cancellation was less than six weeks.
- Taking Imaging and all outpatients on the UCH site and Macmillan Cancer Centre together (including therapies), monthly data from August to December 2015 showed that 10.0%-10.9% of all appointments were cancelled by patients and 11.7%-16% were recorded as cancelled by the trust. The patient cancellation figures included those where the patient called to re-arrange an appointment. Of the appointments cancelled by the trust, most were within the 6 week rule and included where a clinic had to be reorganised or where there had been a data error made during the creation of the appointment and immediately corrected.
- The trust had performed mostly worse than the England average in 2014- 2015 for percentage of people seen by specialist within two weeks from the urgent referral made by the GP. The trust also performed worse than the England average in relation to 31 days from diagnosis to first definitive treatment target, and 62 days target (from urgent GP referral to treatment). In response the trust introduced extended hours and shorter clinics sessions' timetable, and provided staff training to ensure better patient experience. Teams reported that it led to calmer and more organised environment. The new timetable helped to accommodate additional haematology, breast, and gynae-oncology clinics and respond to an increased demand.
- To improve the service the trust also reviewed non-medical prescribing of chemotherapy with a view to release capacity, improve flow, and deliver a better patient experience. They also reviewed clinics schedules to minimize any potential delays and improve utilisation of consulting rooms was maximized. They also ensured there was sufficient time to book a patient visit on the same week the multidisciplinary meeting, where individual patients' clinical conditions were discussed, was held.
- The hospital used an electronic system, in the cancer centre, which allowed tracking patients waiting time from their arrival at the clinic to their appointment. The average time in 2015 was less than 30 minutes, however, figures were based on only 20% of all appointments for which the trust had the start time data.
- There were effective systems for managing non-urgent referrals described by the access policy.
- There was a five day target of an appointment letter to be issued from receipt of referral by the trust. However we were unable to assess how the hospital performed in relation to it as the trust was only in a process of developing monitoring system. The contact centre monitored how quickly they issued appointment letters from the time of rescheduling of appointments.
- The hospital did not monitor time it took to issue discharge summaries after patient's last appointment at the outpatient department. This was an area the trust was developing as it was one of the CQUIN (Commissioning for Quality and Innovation payment framework).goals for 2015/2016.

Outpatients and diagnostic imaging

- The hospital measured the rate of patients who did not attend (DNA) their clinics. Records for March 2015 to February 2016 indicated DNA rate of 10.4% in the cancer centre and 11.3% for outpatient clinics scheduled at the University College Hospital. We observed that the rates were consistent throughout the period. There is no comparable data available for other NHS trusts in England which would allow benchmarking the hospital.
- DNA rate of 8.6%, recorded from April 2015 to February 2016, for diagnostic procedures was better than the England hospital average for outpatients (11.5%).
- Patients told us that they found difficult to access The Mortimer Market Centre, occupied by the dermatology clinics, and that it was "complicated" area to get to. We observed the site was busy with deliveries, workmen moving about and that it was served by a very small ground floor reception. Some of the areas were cluttered with equipment and some of the rooms were very small.

Meeting people's individual needs

- Patient-Led Assessments of the Care Environment (PLACE) 2015 programme indicated that general experience for patients' living with dementia that used the outpatients clinics could improve. The department scored 74% for the measure; it was in line with the hospital average and worse that the England average (80%). There was no action plan in response to findings of the PLACE assessment. These self-assessments are undertaken by teams of NHS and independent health care providers, and include at least 50 per cent members of the public.
- Doctors and nurses told us that a chaperone, usually a nurse or a healthcare assistant was provided on patients' request. Staff received no dedicated training and there was no procedure or policy to guide the practice for providing chaperone.
- Dementia training was not mandated for staff working in outpatients or diagnostic imaging. Director of education told us that 65% of staff completed level 1 dementia awareness training. Patient Information boards in outpatient areas contained guidance on services for dementia and elderly people.
- Staff told us that when patients with a learning disability or who were living dementia attended the outpatients departments their carers were allowed to assist, provided clear patient consent was given. They also ensured patients were seen quickly to minimise the possibility of distress to them. There was 'easy read' information available for people with a learning disability or autism, and their carers. It included information on how to access specialist support services, information on diagnostic procedure such as x-ray or a scan or how to complain about the service.
- Staff told us they had ready access to a translation service should they need it. This meant that patients for whom English was not their first language could engage fully in their consultation. There was an interpretation service available through the language line; however we had not seen any patient information leaflets in different languages other than English.
- Easy to read information leaflets and information in other formats, such as large font or braille, were not readily available. There was no information to advise patients where they could obtain such information. Patients could access leaflets related to various medical conditions online by accessing the trust's website.
- The cancer centre patient portal allowed patients receiving treatment within cancer services to access their appointment schedule and other information held about their care and specific information related to their medical condition from home. Patients could send and receive non-urgent messages to and from their clinical team and.
- Water was available in waiting areas and patients and their relatives could buy snacks and food at the hospital's shop or a restaurant which was accessible to them. There were also vending machines located in waiting areas.
- Most of the clinics were well signposted, however, we observed patients enquiring where to go next or wandering around clinic E area. The clinic appeared busy, and there was no reception or information desk available.

Learning from complaints and concerns

- Individual patients' complaints were discussed during monthly divisional quality and performance meetings and it was a standard agenda item. For example in

February 2015 imaging division staff discussed complaint were a patient felt rushed through their MRI appointment and another one where a patient was unhappy due to cancellation of their appointment.

- Data received from the trust indicated that 47% of all complaints related to outpatients department (932 complaint received January 2014 to December 2015). Most complaints related to neurology (10%) neurosensory (6%) and urology (9%). Most of these complaints related to generic aspects of clinical treatment (39% of all complaints), staff attitude (12%) and appointments delays or cancelations (12%). It took on average 52 days for the complaint to be resolved and closed. Small percentage (3.5%) of all complaints was reopen to allow for further investigation. 3.8% of all complaint took longer than 60 days to investigate and close which was longer than prescribed by the trust's policy.
- Comments boxes were available in reception areas and patients told us they would make use of these should there have any concerns. Information on how to contact patient advice and liaison service (PALS) was also available throughout the hospital.

Are outpatient and diagnostic imaging services well-led?

Good

We found that the service was well-led and rated it as good. There were systems which allowed effective performance monitoring. Risks were listed on local risk registers which were up to date and reviewed regularly. There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging departments. We observed that staff worked well as a team supporting one another. Staff told us they felt able to raise concerns and discuss issues with the managers of the department.

Vision and strategy for the service

- Staff were aware of the trust mission, which was 'to deliver top quality patient care, excellent education and world-class research.'
- Medical specialties' five year strategy included outpatient services. The trust planned to develop specialist rheumatology service, build on clinical trials expertise. They were also focusing on developing new pathways for endocrine patients across North London in partnership with other NHS trusts. It focused on developing new models of care and integration of services through engagement with primary care in management of long term conditions.
- There was a plan to review outpatients' processes to incorporate telemedicine. The trust provided training to front line staff with a view to empower them to redesign and improve outpatients services. They were trained in how to use methods and tools applying 'lean methodologies' to improve services and deliver benefits for patients and staff (lean refers to improvement approach to improve flow and eliminate waste).
- The trust was focused on improving the care and outcomes for cancer patients through research, early diagnosis, centralisation of complex care, and development of innovative service models in diagnostics and radio and chemotherapy. The cancer centre worked in collaboration with The Royal Marsden NHS Foundation Trust and The Christie NHS Foundation Trust to form a collaborative cancer care partnership as part of the National Cancer Vanguard. Vanguards are part of the 'new care models' programme to re-design the NHS, as set out in the 'NHS Five Year Forward' review. Participation in the programme allowed the trust to take a lead on the development of new care models which would act as the blueprints for the rest of the NHS.
- The trust strategic plan 2014-2019 took into account the steady increase in number of outpatient appointments observed since 2009. To address the increase in activity levels the clinical teams focused on developing integrated pathways with primary and community providers.

Governance, risk management and quality measurement

- There were systems which allowed effective performance monitoring. The trust's up to date performance indicators, such as appointment waiting times and those related to diagnostics, serious incidents, infection control, or financial performance, were easily available to local and senior managers in an accessible form. They were able to analyses it to inform their practice and service development.

Outpatients and diagnostic imaging

- There was a radiation protection advisory committee consisting of specialists in radiology, nuclear medicine, medical physics, clinical biochemistry and those working in theatres and other sites managed by the trust. The committee met three times a year and discussed issues radiation related incidents, IRMER training and any other development related to specialty and trust wide developments.
- Local committees and individual divisions reported to trust's committees which provided assurance to the board on the delivery of objectives. It included an audit committee, performance committee and quality and safety.Risks were listed on local risk registers which were up to date and reviewed regularly. It included risk assessments on radiation hazards which were reviewed by radiographer superintendent.
- Governance arrangements were in place and staff were aware of them. Staff working in various departments and specialty areas and were encouraged to attend and participate in governance meetings. Given the management of outpatients and diagnostic services across different divisions we saw little evidence of an overarching strategic governance and management of risk and quality across the divisions.
- Divisional quality and performance meetings took place monthly. Records indicated that risks, as listed on the divisional risks registers, were discussed regularly and new risks were identified and added where relevant. For example imaging divisional meeting held in February 2016 highlighted risks linked to low staffing levels within radiology admin team, and limited access to mammography as there was only one machine at the hospital.

Leadership of service

- There were clear lines of management responsibility and accountability within the outpatient's and diagnostic imaging departments. The outpatients department was managed within the medicine board and the medical specialties division. [ZK1]Outpatients activity provided by the cancer centre was coordinated by the cancer division managed by the surgery and cancer board. Radiology and nuclear medicine belonged to the same board. There was a medical director responsible for each of the boards and a clinical lead allocated to each of the divisions. A matron oversaw outpatients activity and another one was allocated to the cancer centre. Surgical specialties and cancer clinical activity was coordinated by the medical director for the surgery and cancer board which included diagnostic imaging. There was also a medical director for medicine board who coordinated medical specialties division and clinical support division which included therapies, referral and booking, and dietetics.
- The senior managers we met with were aware of departmental strengths and weaknesses and able to explain clear objectives for the development of the department.
- Staff working in various clinical areas told us they were well supported by their managers. Local managers were visible and provided clear leadership. Staff felt that managers communicated well with them and kept them informed about the running of the departments and relevant service changes. We were told that information was communicated effectively.
- General Medical Council survey organised among trainee doctors in 2015 indicated that that trainee doctors working within clinical radiology were not sure who was responsible for their clinical supervision and were dissatisfied with overall quality of the supervision. Director for medical education told us that in response they increased availability of consultant from eight to ten hours per day (9am to 7pm) every weekday. There was also a consultant covering during weekend. They said there were no reported incidents of trainee doctors being unable to contact the covering consultant.
- The action plan prepared in response to the survey also indicated that changes were made to ease workload related pressures on trainee gastroenterologists. The trust monitored the workload through the end-of-placement feedback questionnaires.
- Trainee doctors within clinical radiology and haematology had also pointed out they had difficulties with attending regional training sessions. The trust said it was partially due to organisational issues related to UCL Partners who facilitated it. Action plan indicated that emails were to be sent to trainees requesting information on any difficulties they experienced in attending training, and explaining the proposed changes to the way teaching is delivered across the region. Individual specialties were required to keep a record of trainees going to training days.

Outpatients and diagnostic imaging

Culture within the service

- Staff thought there was "always a good teamwork and staff were always helping one another". They were committed and proud of their work and positive impact it had on patients.
- Staff told us they felt able to raise concerns and discuss issues with the managers of the department.
- There was no detailed plan for outpatient department or diagnostic imaging in response to the General Medical Council survey organised among trainee doctors in 2015. This survey indicated that the hospital underperformed in relation to clinical supervision, educational supervision and overall satisfaction. The hospital prepared a generic action plan in response to the survey undertaken in 2015;
- There was a divisional action plan for 2015/2016 in response to the NHS staff survey results. It focused on key areas were improvement was needed such as communication, staff development, team building and line management and leadership. Actions were clearly highlighted and allocated to managers and senior members of staff.

Public and staff engagement

- The outpatient department organised outpatients away days in March 2015 led by the deputy chief nurse for medicine department and the department's matron. Part of the day was focused on discussing staff survey results and engaging staff in defining what common purpose for the departments should be.
- Training sessions were organised which focused on general patient experience and experience of a person using a wheelchair with a view to facilitate better understanding among the staff and help to ensure good patient experience. Staff were encouraged to try to understand patients' expectations, emotions, and stereotypes patients might have of the service and come up with ideas for supporting patients through their appointment.

Innovation, improvement and sustainability

- The trust developed a database for diagnostic imaging that showed acute referrals awaiting a scan and a report. The database allowed all clinicians to track progress of acute patients on the imaging pathway. This helped to reduce interruptions, improve patient safety and improve turnaround times.
- The prostate cancer service won award for acute sector innovation from a national health journal. The trust found that prostate magnetic resonance imaging (MRI) allowed men without cancer to avoid biopsies; and those with a suspicious lesion to have accurate, targeted biopsies. Its prostate cancer pathway allowed men to have clinical review, MRI and transperineal targeted-biopsy all on one day. The journal had noted that one in three men coming to the trust avoided a biopsy as a result of this development, while cancer detection has gone up by a third. It also allowed increasing capacity by reducing number of patient visits and diagnosis times.
- A number of research and development initiatives were undertaken at the hospital. In November 2015 the first ever positron emission tomography MRI scan of the new neuro-receptor imaging agent (18FGE-179). Researchers believed it would benefit patients who experience seizures either as a consequence of epilepsy, stroke or traumatic brain injury.
- Quality and safety board and daily departmental huddles were introduced in 2015. Staff were talking positively about these changes and how it improved communication across departments.

Outstanding practice and areas for improvement

Outstanding practice

- There was outstanding local leadership in critical care with high levels of staff and patient engagement.
- In maternity and gynaecology we saw examples of outstanding practice including the integrated " one stop" service providing an efficient diagnosis and treatment facility.

Areas for improvement

Action the hospital SHOULD take to improve

- Examine its streaming process in ED and seek to engage ED staff in developing a system that meets the needs of patients in ED.
- Significantly reduce average time spent per patient in ED.
- Shorten the time to initial assessment of patients in ED.
- Ensure full incident reporting, investigation and learning takes place
- Examine emergency cover in ED to ensure it meets College of Emergency Medicine recommendations.
- Ensure that any risks of alleged and potential bullying are understood and ensure that the trust takes action where that bullying is known or arises.
- Ensure consistent and full recording or early warning scores, sepsis screening and pain management.
- Ensure mandatory training targets are met consistently.
- Ensure timely and sufficient information is sent to the trust board.
- Ensure that all risks identified are noted on the risk register.
- Examine recording of patient records and ensure improvements to meet consistent best standards across all wards.
- Examine effectiveness of treatment across medical wards to comply with national guidelines to improve patient outcomes.
- In medical care and all areas ensure that care of patients living with dementia or learning disability goes beyond mere identification and devise clear care pathways to meet the needs of these patients.
- Review the policy on admitting paediatric patients in critical care including the management of paediatric patients on the adult critical care unit to assure delivery of safe and effective care.
- Make necessary improvements on patient waiting times for treatment including referrals and emergency referrals from GPs.
- Ensure improvements to diagnostic waiting times.
- Review performance against the 31 day target from diagnosis to first definitive treatment, produce and improvement action plan and monitor performance against that action plan.
- The above list is not exhaustive and the trust should examine the report in detail to identify all opportunities for improvement when determining its improvement action plan.