# University College London Hospitals NHS Foundation Trust

## Quality Report

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

## Ratings

| | |
|---|---|
| Overall rating for this trust | Good |
| Are services at this trust safe? | Requires improvement |
| Are services at this trust effective? | Good |
| Are services at this trust caring? | Good |
| Are services at this trust responsive? | Good |
| Are services at this trust well-led? | Good |

# Summary of findings

## Letter from the Chief Inspector of Hospitals

University College London Hospitals NHS Foundation Trust (UCLH) is an NHS foundation trust based in London. It is made up of University College Hospital (UCH) and Elizabeth Garrett Anderson Wing, UCH at Westmoreland Street, UCH Macmillan Cancer Centre, the National Hospital for Neurology and Neurosurgery, the Hospital for Tropical Diseases, the Royal London Hospital for Integrated Medicine, the Royal National Throat, Nose and Ear Hospital and the Eastman Dental Hospital.

The trust has an annual turnover of approximately £930 million and employs around 7600 staff.

In partnership with University College London, UCLH has major research activities and is part of the UCLH/UCL Comprehensive Biomedical Research Centre and the UCL Partners academic health science centre.

The trust is also a major teaching trust offering training for nurses, doctors and other health professionals in partnership with various universities and UCL Medical School.

Our key findings were as follows:

- Overall we rated University College Hospitals NHS FoundationTrustas good.
- We rated surgery, critical care, maternity and gynaecology, services for children, and outpatients anddiagnostic imagingas good. We rated urgent and emergency care and medical care as requires improvement.
- 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.
- Inmaternity and gynaecology we saw examples of outstanding practice including the integrated " one stop" service providing an efficient diagnosis and treatment facility.
- 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 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.
- 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.

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- 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.
- 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 should:

- 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 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.
- 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.

**Professor Sir Mike Richards**
**Chief Inspector of Hospitals**

# Summary of findings

## Background to University College London Hospitals NHS Foundation Trust

University College London Hospitals NHS Foundation Trust (UCLH) is an NHS foundation trust based in London. It is made up of University College Hospital (UCH) and Elizabeth Garrett Anderson Wing, UCH at Westmoreland Street, UCH Macmillan Cancer Centre, the National Hospital for Neurology and Neurosurgery, the Hospital for Tropical Diseases, the Royal London Hospital for Integrated Medicine, the Royal National Throat, Nose and Ear Hospital and the Eastman Dental Hospital.

The trust has an annual turnover of approximately £933 million and employs around 8100 staff.

In partnership with University College London, UCLH has major research activities and is part of the UCLH/UCL Comprehensive Biomedical Research Centre and the UCL Partners academic health science centre.

The trust is also a major teaching trust offering training for nurses, doctors and other health professionals in partnership with various universities and UCL Medical School.

The trust balances the provision of nationally recognised, specialist services with delivering acute services to the local populations of Camden, Islington, Barnet, Enfield, Haringey and Westminster. The combined population of these unitary authorities is 1.626 million.

Deprivation is higher than the England average in Camden, Islington, Enfield, Haringey and Westminster, however it is lower in Barnet. In total 78,600 children live in poverty across these six unitary authorities.

## Our inspection team

The inspection was led by the Chair, Prof 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. We held events during the inspection when staff and patients and members of the public could come and talk to us to share their experience.

## How we carried out this inspection

To get to the heart of patients' experience of care in this acute trust we 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?
- 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

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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.

We inspected eight core services, but as end of life care was provided under a service level agreement by an external provider, which we have previously inspected and rated, we have not rated end of life services in this report. However, we have described our findings on this service in the report.

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

- The trust performed better than the England average for all four areas in the 2014 Patient Led Assessments of the Care Environment (PLACE).
- The trust was consistently above the England average in the Friends and Family Test (% recommended) August 2014 to November 2015.
- The number of written complaints received by the trust has increased each year between 2011/12 and 2014/15. It should be noted that the number of patients contacts has also increased during the same time period. There has been no increase in complaints per 1000 contacts.
- The trust performed "about the same" as other trusts for 11 out of 12 of the selected questions in the CQC Inpatient Survey 2014, however it is noted that performance against this survey measure had improved in comparison to 2014. In one question, the trust were amongst the worst performing trusts for the availability of hand-gel for patients and visitors. The 11 questions where the trust performed about the same as other trusts were as follows: Did you get enough help from staff to eat your meals? Did doctors talk in front of you as if you weren't there? When you had important questions to ask a nurse, did you get answers that you could understand? Did nurses talk in front of you as if you weren't there? Were you involved as much as you wanted to be in decisions about your care and treatment? Did you find someone on the hospital staff to talk to about your worries and fears? Do you feel you got enough emotional support from hospital staff during your stay? After you used the call button, how long did it usually take before you got help? Did a member of staff answer your questions about the operation or procedure? On the day you left hospital, was your discharge delayed for any reason? How long was the delay?
- The trust was in the bottom 20% of trusts for 16 of the 34 questions in the Cancer Patient Experience Survey. 2013/14.

**Health Education England**reported the following:

- Trainees received excellent supervision and learning experiences.
- The trust's vision of taking the educational strategy forward was excellent.
- There were reports from trainees regarding the uncertainty and confusion of pathways for paediatric patients under two years of age. The trust was required to clarify the pathway and communicate it to all staff in an effort to reduce trainee anxiety and limit potential patient safety concerns.
- A potential lack of handover resulting in a compromise in patient safety for private oncology and/or haematology patients.
- Locum doctors not receiving an induction and trainees regularly sharing electronic log-in details for locums to access patient records.
- A lack of safe staffing and skill mix (nursing) for the care of patients including 1-6 patients with airway needs on the T14 ward.
- There was no protected theatre time in surgery for core surgery trainees.
- Job plans were being reviewed by the Trust. The visit team recommended that for the educational work to continue, dedicated time in job plans should be allocated.
- Lack of space to undertake private / confidential meetings, or to provide hands-on training. The Trust was encouraged to look at the process of reorganisation and ensure that opportunities were not compromised.

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**Royal College of Nursing**cited the following issues with regard to the trust:

- The trust is facing recruitment and retention of staff issues though it is being proactive in identifying solutions to recruitment difficulties and is piloting some retention initiatives.
- The RCN cited issues with newly recruited staff receiving timely training in basic life support, moving and handling and paediatric life support
- The RCN expressed some difficulty in obtaining financial updates from the trust.

**NHS England**reported the following concerns and stated that the trust had responded to these with action plans:

- Lack of histopathologist in cancer/haemato-oncology.
- Lack of functioning multi-disciplinary working in cancer services.
- Some issues re accessibility to CT scanners at the main hospital site.
- Lack of an integrated trauma rehabilitation service.
- IT infrastructure not robust..

**Camden and Islington CCGs**reported the following main points:

- Improved executive ownership of infection prevention and control.
- Low HSMR and SHMI mortality rates cited as a positive indicator of safety.
- Trust clinical outcomes are positive.
- Electronic transfer of patient discharge information not yet complete.
- Lack of sharing of WHO safety checklist audits.
- Positive indicators of good care for those patients receiving timely care.
- On-going difficulties meeting diagnostic and cancer targets with trust failing to meet targets for 62 cancer waits and some issues of capacity in diagnostics.
- Delays in urological cancer patient pathways.
- Good clinical and managerial leadership.
- Some concerns about administrative inefficiencies.
- Improvements noted in listening to patient voice and improved innovation and initiatives in patient engagement.
- Improvements noted in collaboration with CCGs in service redesign.
- Good collaborative approach with other providers in relation to paediatric diabetes.

**NHS Staff survey:**

- The trust had mixed results in the 2014 NHS Staff Survey. The overall engagement score was higher than the National average. There were seven negative findings and ten positive findings from 30 questions asked. The trust's performance was also slightly worse overall than the 2013 survey.

## Facts and data about this trust

### Key figures

• **Beds**: 812

– 716 General and acute

– 96 Critical care

• **Staff**: 8,100

– 1,396 Medical

– 2,576 Nursing

– 3,645 Other

• **Revenue**: £933,936 m

• **Full Cost:** £931,483 m

• **Surplus (deficit):** £2.453 m

### Activity summary (Acute)

**Activity type 2014-15:**

Inpatient admissions **:**170,359

Outpatient (total attendances) : 1,054,816

Accident & Emergency (attendances) : 135,000

# Summary of findings

## Our judgements about each of our five key questions

| | Rating |
|---|---|
| **Are services at this trust safe?**<br>Overall we rated safety at the trust as requires improvement. We rated safety as good in surgery, critical care, maternity and gynaecology, services for children and young people and outpatients and diagnostic imaging. However we rated safety as requires improvement in the emergency department and medical care.<br>• In the emergency department (ED), 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.<br>• Patients experienced significant delays in initial assessment and treatment.<br>• In medical services 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 and evidence that appropriate checks were not always completed when administering infusion medicines.<br>• 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.<br>• Escalation of deteriorating patients was not always correctly completed or fully documented and there was not evidence of a systematic identification of cases during our inspection. 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.<br>For more detailed information please refer to the reports for the individual acute services.<br>**Incidents**<br>• 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. | **Requires improvement**  |

- Staff in ED informed us they were encouraged by managers and colleagues to complete incident reports. They told us charge nurses speak 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.
- 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 in medical care 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.
- 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 looked at the investigation of two serious incidents in critical care. Both were fully investigated using the serious incident framework, learning shared and an action plans were developed as a result.
- 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
- Staff in services for children and young people 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. .
- Staff in OPD 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.

### Safeguarding

- The trust 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 safeguarding training. Levels of compliance with this target were variable. Higher percentages of nurses than medical staff had completed safeguarding training. Percentages were as low as 58% of medical staff in some areas to over 90% of nursing staff in other areas of the trust.

### Nursing staffing

- Levels of nursing staffing in the trust varied according to workload measurements such as patient dependency and activity, benchmarking with other organisations and professional consultation. Nursing staffing ratios to patients were different in each core service:
- In ED care there was a planned nurse to patient ratio of 1:4 during the day and 1:7 during the night.
- Trust 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.
- In surgery senior ward sisters told us nurse staffing levels were challenging to manage due to the recent reduction in agency staff use in the trust. In critical care 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.
- The Royal College of Nursing (RCN) recommend a nurse to patient ratio of 1:8 in maternity (RCN 2012). We saw a safe staffing board that demonstrated planned staffing met actual staff ratios for each shift in maternity and gynaecology.
- In services for children and young people the department met the 2012 Royal College of Nursing (RCN) staffing guidelines, detailing the minimum essential staffing requirements for all providers of services. for babies, children and young people.
- In OPD 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.

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### Medical Staffing

- The emergency department provided 16 hours consultant cover from 8am to 12 midnight 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.
- On medical wards 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 junior doctors (14% in comparison with 22%).
- 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%.
- In critical care, 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.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations.
- 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%).
- 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.

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### Duty of Candour

- The trust had promoted duty of candour and this was seen to be cascaded through the organisation. Most staff were aware of the requirements and gave examples of the duty of candour, including apologising and sharing the details and findings of any investigation.

### Environment and Equipment

- In ED we observed pieces of equipment, such as resuscitation trolleys had been checked and labelled for their yearly inspection with clinical engineering.
- 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.
- Monthly environmental audits were completed across the medical wards by representatives from infection control, estates and clinical support services.
- The theatre department at 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.
- The critical careenvironment and equipment was clean and supported safe care. It was fit for purpose andcritical care staff complied with infection prevention and control guidelines.
- In maternity services 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.
- In children's services we found clinical areas to be clean, well lit, bright environmentally child friendly with appropriate equipment.
- In OPD, 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.

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### Cleanliness infection control and hygiene

- 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 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.
- Infection prevention and control at both UCH and UCH at Westmoreland Street was well managed. Clinical areas we visited were visibly clean, tidy, well organised and clutter-free.
- 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.
- 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.
- The trust followed their policies and procedures for hand hygiene and infection prevention and control and audited hand hygiene on a monthly basis.
- Clinical areas in OPD 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.

### Medicines

- In ED 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. Some staff we spoke to were not aware which emergency medication was available to them and how to use it.
- 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.

- In medical care 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 and evidence that appropriate checks were not always completed when administering infusion medicines.
- 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.
- In surgical services medicines, including controlled drugs (CDs), were stored and managed appropriately, were securely locked and checked daily on all surgical wards and in theatres.
- We were told that, trust wide,newly qualified nurses had to pass a competency assessment before administering medicines independently.
- In surgical services 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 found in maternity 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.
- There were processes in place to support staff in managing medicines safely and to relieve symptoms of patients with a terminal illness or those in the last stages of life.

**Records**

- An electronic patient system ran alongside paper records and allowed staff to track patients' movement and to highlight any delays.
- In ED Early Warning Scores (NEWS), sepsis screening, and pain management were not consistently recorded in patient records.

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- 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 medical services 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 in medical servicesand 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.
- 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.
- In surgical wards patient records were kept in trolleys in wards areas. These trollies were not locked.
- In critical care patient records were comprehensive, with all appropriate risk assessments completed.
- 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.
- We saw that patient records were stored securely on the gynaecology and maternity wards.
- In the neo natal unit (NNU), patient records were multidisciplinary where all professionals including therapist and nutritional team could contribute to the individual baby's record.
- In OPD patients' records were comprehensive and clearly described patients' treatment plans, medical histories and any relevant risk assessments. We observed that patients' records were occasionally left unattended in open trolleys outside of consulting rooms in general outpatient areas.

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### Mandatory Training

- Trust mandatory training covered subjects including safeguarding, conflict resolution, information governance , fire prevention, infection control, medicines management.
- 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.
- 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 and 68% of doctors within gastrointestinal doctors had completed conflict resolutions training.
- 90% of all critical care staff achieved the trust target for all mandatory training modules.
- In maternity and gynaecology 87% of the nurses and midwives had completed mandatory training compared to the trust target of 90%.
- The neonatal unit staff's compliance with mandatory training was 96% and above the trust target.
- The trust did not include end of life care in their mandatory training programme. The SPCT had requested this become part of mandatory training, but senior staff told they did not think this would be prioritised over other demands for mandatory training.

### Assessing and responding to patient risk

- In line with NICE guidance, the 'National Early Warning Score' (NEWS) was used 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).
- 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.
- Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women 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.

# Summary of findings

- 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 hospital had processes in place to assess and respond to risk and to identify patients who might be entering the last months or days of life. Nurses and health care assistant staff monitored all inpatients regularly and used an Early Warning Score (EWS) to identify patients who were deteriorating.
- In OPD 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.

### Major incident awareness and training

- There was a trust-wide major incident policy that was available to all staff via the hospital intranet. This had been reviewed in February 2016. 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.
- The trust had a department leads for major incident awareness, and a full plan was in place for escalation in the event of escalation of demand and resources. There was an action card for each hospital ward. Senior staff told us that there was a plan to deal with surges in demand in the event of a major incident.

## Are services at this trust effective?

Good

Overall we rated effectiveness of services at the trust as good. We rated effective as good in urgent and emergency care, medical care, surgical services, critical care, maternity and gynaecology, and services for children and young people.

- The emergency department (ED) was following applicable national guidance and using 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.

# Summary of findings

- 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 was good. Most services within the department were accessible over a 24 hour period.
- Local audits were being undertaken though action plans were not always implemented. However, there was recognition that improvement following audits was required. 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.
- In medical services 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.
- In surgery 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.

# Summary of findings

- 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.
- In critical care 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.
- In maternity services 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.

# Summary of findings

- 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 Integrated 'One Stop' service as an efficient diagnosis and treatment facility, surgical management of miscarriage under local anaesthetic in the Early Pregnancy Unit and integrated multi disciplinary working within the Fetal Medicine Unit.
- Children's 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. .
- In children's services 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.
- The Specialist Palliative Care team's (SPCT) work at the hospital was based on best practice. The SPCT had obtained funding for the Transforming End of Life Care (TEOC) programme to enable ward staff to provide a good standard of care. This was supported by guides and tools, education on the wards and formal training sessions on communication. The TEOL team gathered date to measure the effectiveness of the programme.
- The SPCT submitted data to the national audit and undertook a programme of local audits, agreed by the trust. They used the results to make improvements to services.
- There were many examples of good multidisciplinary working, within the SPCT, within ward-based teams, across the trust and with external agencies.
- The project to improve the standard of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders had been successful.
- However, the patient record systems did not collect data on key indicators for end of life care. The SPCT collected data manually from records, gathered information on patients' preferred place of death, and conducted surveys of staff and bereaved relatives to monitor the effectiveness of their programme.

# Summary of findings

For more detailed information please refer to the reports for the individual acute services.

**Evidence-based care and treatment**

- The emergency department 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.
- On medical wards 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.
- 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.
- In critical care, 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 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.
- 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.
- The members of the specialist palliative care team (SPCT) were skilled and knowledgeable. Their work at the trust reflected national guidance and recommendations from expert bodies, including the Leadership Alliance for the Care of Dying People 'Five Priorities of Care', published in 2014.

- 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.

### Pain relief

- The trust pain team extended its remit in January 2016 and aimed to support emergency department as well as other departments. They provided expert support and advice to offer patients 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.
- In ED 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.
- On medical wards, 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. Patients told us their pain was generally well managed and most agreed that they receive pain relief in a timely manner.
- In surgical services, staff 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 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. Patients told us their pain was regularly assessed and pain relief was given when needed.

- The critical care unit (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.
- Women we spoke with in maternity and gynaecology felt that their pain and administration of pain relieving medicines had been well managed.
- In services for children and young people 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.
- The trust pain team wrote the policy on managing pain in end of life care (EOLC), which reflected national and international good practice. Medical and nursing members of the team came to the wards to give advice when staff requested this. Pharmacists also supported trainee doctors in prescribing for pain relief, including measured doses delivered by pump for people in the last days of life.
- Patients attending outpatients and diagnostic services 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.

**Patient outcomes**

- In the emergency department planned local audits of care of patients at risk of sepsis had not been undertaken. Senior staff told us that a new sepsis initiative was being launched later this year (UCLH Sepsis) within the department. 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.

- 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.
- 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).
- 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%).
- In medical care, in the most recent national Heart Failure Audit in 2013/4, the trust performed better than the national average for all indicators relating to inpatient care and discharge from hospital.
- In the most recent (2013) results from the 'National Diabetes Inpatient Audit' (NaDIA), the trust performed worse than the national average in 14 out of 20 domains.
- The trust participated in the 'Myocardial Ischaemia National Audit Project' (MINAP), which assessed the management of patients with a heart attack. In results published in 2015 (for patients seen during the period 2013/14), : The trust as a whole performed better than England average on 6/6 MiNAP nSTEMI questions.
- 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 except urology are now compliant with the 18 week RTT target.

- 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 andincreased comorbidities within these patient groups.
- Non-elective care had about the same readmission rates compared to the national average.
- The trust critical care 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.
- 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.
- 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 maternity dashboard from April to November 2015 demonstrated that the caesarean section rate was 29.1%, 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%. The emergency caesarean rate was 16% compared to the national average of 14.7%. The trust shared an RCOG analysis which demonstrated that the trust was not an outlier after correction for casemix.
- The trust performed well in the National Paediatric Diabetes Audit 2013/2014. The percentage of children with an HbA1c level of less than 7.5 was 23.9% compared to an England average of 18.5. 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 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 SPCT and EOL teams collected data for national audits and for internal audits to monitor progress against objectives set in the trust service specification The results indicated that the teams were providing an effective service. However, data was not available for all patients known to the hospital who were terminally ill or in the last stages of life. When data was available this indicated further work was needed in hospital as a whole
- 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.

# Summary of findings

### Competent staff

- Staff throughout the trust told us there was good access to training. The trust circulated emails detailing what training opportunities were available to staff.
- 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.
- 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.
- 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 including bank and agency staff 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.
- 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.
- New nurses on the critical care unit (CCU) 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.

- 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.
- 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.
- The neo-natal unit (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.
- There were a number of strands to the training programme for end of life care, but some of the 4,000 medical and nursing staff at the trust had not received any training in end of life care. There was an emphasis on increasing staff confidence in talking to patients about the end of life. However, there was no record of the number of consultants who received training in this.
- 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.
- 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%.

**Multidisciplinary working**

- In ED twice daily handovers were attended by nursing, medical and management staff.

# Summary of findings

- A number of specialty teams were accessible to staff including specialist services, mental health support and drug and alcohol treatment services.
- Staff in the Emergency Medical Unit (EMU) 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.
- 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.
- In surgical services 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. We attended one of these meetings and observed the MDT working together to promptly discuss and address any concerns.
- 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 learning 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.
- During handover, we were impressed 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.
- In services for children and young people 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”.
- Close multidisciplinary working between consultant, medical and nursing staff within the SPCT and between the team and hospital staff was key to promoting good care for people in the last year of life. However, consultants were not regularly present on cancer services wards.
- The weekly specialist palliative care meetings were attended by consultants and nurses from the SPCT, a bereavement officer and chaplain. The group discussed the care and treatment of each of the patients who referred to the team. The discussion included spiritual needs of patients and what, if any, additional support the multi-faith chaplaincy service could provide. The meeting checked if the patients’ Preferred Place of Death (PPD) was known.
- Many OPD 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.

### Seven-day services

- The ED reception, AAU, 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 hours per day.
- 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.

# Summary of findings

- Medical and nursing staff provided cover on both sites for 24-hours a day, seven days a week.
- 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.
- In maternity 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.
- Support services for children and young people 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.
- 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.
- 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.
- The specialist palliative care team (SPCT) provided a five-day service 9am to 5pm and an on call service out of hours. Pharmacy and discharge staff were present at the hospital seven days a week.
- 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.

# Summary of findings

### Access to information

- The trust used a mixture of paper based and electronic systems to record patient details and this limited the amount of information to which staff had easy access.
- The trust 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.
- 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.
- 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.
- 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.
- 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

- There was an up to date policy regarding consent, mental capacity and deprivation of liberty safeguards which was accessible to staff on the intranet.
- We observed staff obtaining consent from patients before procedures or tests were undertaken, including the recording of verbal consent.
- In ED 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.

# Summary of findings

- 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.

**Are services at this trust caring?**

Good

Overall we rated caring at the trust as good. We gave the rating of good for caring to all the core services we inspected and rated.

- In the emergency department (ED) 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.
- In medicine we observed some situations where patient privacy and dignity were not fully maintained and the use of surveillance cameras in endoscopy was not appropriate. We also 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.
- However,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. Additionally, 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.We rated the surgery service at the trust 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.

# Summary of findings

- Patients' emotional and social needs were consider by staff and were embedded within their care and treatment pathways.
- We rated 'caring' as good in critical care because The 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 at the follow up clinic.
- Patients' feedback was sought and the latest yearly friend and family test results showed 95% of patients would recommend the CCU.
- Overall, we rated the maternity 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'.
- In children's services patients 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.

- In end of life services we observed examples of staff interacting with patients and those close to them with kindness and respect. Families of patients who were dying or had died at the hospital reported that staff treated their relative with respect and dignity.
- Relatives said staff gave them the information and support they needed. Ward staff, porters and mortuary staff treated the deceased with dignity. Bereavement staff provided sensitive support to families.
- We rated outpatient and diagnostic services as good for caring. 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.

For more detailed information please refer to the reports for the individual acute services.

**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.
- The majority of patients we spoke with were positive about the care they received. Patients told us staff were "excellent" and "highly professional".
- Hospital staff in areas such as the Acute Medical Unit and care of older people's wards provided compassionate care to patients at the end of life. Consultants explained to patients and those close to them the options for treatment and when a do not attempt cardiopulmonary resuscitation order (DNACPR) was in the patient's best interest.
- 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.

### 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.
- 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.
- 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.
- 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.
- Women in maternity 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.
- Staff were described as having a high level of expertise and helped to involve parents in the care of their children and babies.
- Involving patients, those close to them or both was central to the work of promoting good end of life care at the hospital, following national guidance.

### 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".

# Summary of findings

- Clinical nurse specialists provided support to patients throughout their surgical pathways. Patients complimented the support they were given and liked this consistent point of contact throughout their care
- 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.

**Are services at this trust responsive?**

Good

Overall we rated responsive at the trust as good. We rated responsiveness in medical services, surgery, critical care, maternity and gynaecology and services for children and young people and outpatients and diagnostic imaging as good. We rated responsiveness in urgent and emergency care as requires improvement.

- The ED recognised the need to response to the increasing demands for its services but service redesign to address these demands failed to meet patients' needs or to adequately address issues with patient flow.
- Though the ED leaders were aware of the needs of the local population, the focus of the service redesign was not tailored to adequately address these specific needs
- The total time in the ED (average per patient) for the trust was consistently significantly higher than the national average.
- The percentage of emergency admissions via A&E 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. However, from July 2015 to November 2015 there was a trend upwards to a point and since has exceeded England average.
- Complaints and concerns were responded to, but the ED was not able to evidence that learning had taken place consistently.
- However the ED has consistently performed better than the England average to see, treat and discharge 95% patients within 4 hours since November 2014 to the time of our inspection.
- Within medical services we noted 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.

# Summary of findings

- 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. There were a low proportion of patients discharged before 11am (Between 11.8% and 20.3% during November 2015 to January 2016 in comparison with the 35% trust target) however patients used the discharge lounge to assist with patient flow issues.

For more detailed information please refer to the reports for the individual acute services.

**Service planning to meet the needs of local people**

- ED staff were familiar with some information regarding the demographics of the people that used the service. However there was little evidence of service planning taking this into account. Due to its location there were a high number of patients walking in - from between 400 and 450 per day.
- Staff within medical services identified a changing population and an increased need for elderly care beds. A task force including local stakeholders was implemented to identify and address gaps in services.
- The trust was actively working with commissioners to provide an appropriate level of service based on demand.
- The trust opened an additional nine bedded unit in the CCU in June 2015 at Westmoreland Street to assist with patient recovery.
- Planning of services took account of the fact that many patients attended the trust services from areas beyond the trust's local catchment area, for example cancer patients.

**Access and flow**

- A new model for streaming patients had been introduced in the weeks before our inspection. It was not yet well understood by staff in ED.
- Patients accessed medical services after being admitted via the emergency department or were booked admissions for planned treatment. Most patients were non-elective emergency admissions.
- Senior staff told us that maintaining effective patient flow was a high priority. There was a dedicated discharge team available seven days per week to assist with discharge pathways when there were delays.

# Summary of findings

### Meeting people's individual needs

- There was support across the trust from a learning disability nurse specialist to provide best practice care for patients with learning disabilities.
- People living with dementia on medical wards had a blue forget me not flower next to their name. However it was unclear what difference this made to patient care.
- Surgery services proactively considered and responded to specific individual needs including patients with complex needs and cultural and religious requirements.
- The trust provided interpreting services 24 hours per day seven days per week.
- The specialist palliative care team was proactive in assisting ward staff provide personalised care for palliative care patients.
- A multi-faith chaplaincy service was available throughout the trust.

### Learning from complaints and concerns

- A trust complaints manager was responsible for handling complaints in line with trust policy.
- Staff on wards attempted to deal with complaints on an informal basis. Staff would direct patients to the Patient Advisory Liaison Service (PALS) if they were unable to resolve the issue informally.
- The trust had information leaflets readily available on how to make a complaint. Complaints were monitored at ward and division level. Quarterly reports were sent to divisional boards.
- Staff were able to give us details of how learning from complaints had led to changes in care practice.

### Are services at this trust well-led?

Good 

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

- The organisation has a well-established leadership team and a long-standing model of tripartite management (nursing, medical and general management), reporting to a senior clinical Divisional Director. The organisation had a clear vision and a well developed strategy for the delivery of specialist care and research. It had taken a lead amongst specialist providers in London to ensure that specialist services are of sufficient size to deliver high quality care.
- Local services, i.e. emergency care for the local population, also feature in the trust strategy and it was noted that capital investment had been identified to the support the development of the Emergency Department.

# Summary of findings

- The trust has taken the lead in developing an academic health sciences centre and subsequently an academic health sciences network, building strong clinical and academic partnerships locally within London and across a wider area.
- We rated many services as good, however some areas were rated as requires improvement. These included the leadership of the ED, medical care. We rated leadership within surgery as outstanding.
- Within the ED 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.
- We rated well-led in medical services as requires improvement 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.
- 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. However, there was a positive culture on the medical wards and staff told us they enjoyed their work.
- We rated the surgery service at the trust as outstanding for well-led.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.

# Summary of findings

- 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.

For more detailed information please refer to the reports for the individual acute services.

**Leadership**

- At the time of inspection, the senior leadership team comprised of a well-established leadership team. The Chair, Chief Executive Officer, Corporate Medical Director, clinical Medical Director's were all long-standing substantive appointments. The Deputy Chief Executive, Chief Nurse and Interim Finance Director were new appointments within the prior 12 month period.
- The organisational Divisional structures consisted of a mature , well embedded model of tripartite (medical, nursing and general management) management.
- Divisional leadership teams were sufficiently skilled to lead their departmental teams. Leaders were visible and staff said they were supported with leaders understanding the challenges they faced.
- However there were some issues of support from senior staff to ED staff during the recently introduced streaming changes in the department.
- Staff told us that senior trust managers were visible throughout the trust.

**Vision and strategy**

- The trust has a well developed clinical and academic strategy encompassing both its specialist services and services for its local population.
- The trust described their vision to deliver top quality patient care, excellent education and world class research.
- There was a balance and tension between the delivery of world class specialist services and delivering acute services to the local population.
- Individual divisional strategies linked in with the trust overall vision and strategy.
- We found staff were able to articulate the vision and values of the organisation

**Governance, risk management and quality measurement**

- Clinical governance structures were in place across the trust. There was a well-defined structure. Most staff we spoke with were aware of these structures and reporting procedures.

# Summary of findings

- The governance structure had a clear line of sight from ward level, which fed Divisional governance, and in-turn informed Corporate and Board discussions. The senior executive leaders were sighted on the risks that we observed, corroborated through interviews and reviewing Board minutes and discussions.
- Senior clinicians met regularly with divisional management team to discuss risk management and quality of service and performance.
- Morbidity and mortality meetings were held at varying intervals depending on the division.
- End of life care was provided by an external provider under a service level agreement. There was a lack of clarity about how the trust monitored this.

**Fit and Proper Persons Requirements**

- We reviewed ten sets of executive and non-executive personnel files. We found that all had evidence of FPPR checks, DBS checks, director and insolvency checks. We found the trust to be compliant with FPPR requirements.

**Culture**

- Staff described a no blame culture where they were encouraged to report incidents. They generally believed that there was a learning culture to improve care as a result of incidents and complaints.
- Staff told us their views were listened to and their professional judgement was respected. Senior managers were concerned for the welfare of staff.
- Staff expressed satisfaction at working in professional supportive teams throughout the trust.
- There was a strong commitment of staff to the trust's vision of excellent care, education and research.

**Public and staff engagement**

- Questionnaires were used to gain levels of satisfaction with patient care. These were audited to disseminate learning from them.
- Many wards used " You said we did" display boards to show what action had been taken as a result of patient feedback.
- The OPD department organised annual away days to focus on staff survey results and concentrating on strategy and patient care.

# Summary of findings

### Innovation, improvement and sustainability

- The trust is has major research collaborations through its academic health sciences centre and biomedical research centre.
- It had taken the lead, working with partners from across the local healthcare system in the development of a leading academic health sciences network.
- Staff and divisions were actively involved in initiatives to improve patient care, the environment and patient experience. These are detailed under each core service in the hospital location report.

# Overview of ratings

## Our ratings for University College London Hospitals NHS Foundation Trust

| | 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 | N/A | Good | Good | Good | Good |
| **Overall** | Requires improvement | Good | Good | Good | Good | Good |

## Our ratings for University College London Hospitals NHS Foundation Trust

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

# 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 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.