

Barts Health NHS Trust

Whipps Cross University Hospital

Quality Report

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

Ratings

Overall rating for this hospital

Inadequate



Urgent and emergency services

Requires improvement



Medical care (including older people's care)

Requires improvement



Surgery

Inadequate



Critical care

Requires improvement



Maternity and gynaecology

Good



Services for children and young people

Good



End of life care

Requires improvement



Outpatients and diagnostic imaging

Inadequate



Summary of findings

Letter from the Chief Inspector of Hospitals

Whipps Cross University Hospital in Waltham Forest is part of Barts Health NHS Trust, the largest NHS trust in the country, serving 2.5 million people across Tower Hamlets and surrounding areas of the City of London and East London.

Whipps Cross University Hospital provides a range of general inpatient services with 636 beds, outpatient and day-case services, as well as maternity services and a 24-hour emergency department and urgent care centre. The hospital has various specialist services, including urology, ENT, audiology, cardiology, colorectal surgery, cancer care and acute stroke care.

Waltham Forest is in the most deprived quintile of local authority districts and about 25% of children (14,500) live in poverty. The population includes 47.8% BAME residents.

We returned to inspect this location (and the Royal London location) to follow up on our previous inspections of Barts Health NHS Trust in 2014 and 2015 where we found a number of concerns around patient safety and the quality of care. Following the last inspection, significant changes were made to the leadership of the organisation at both an executive and site level.

We carried out an announced inspection between 26 and 29 July 2016. We also undertook unannounced visits on 2 and 4 August 2016.

We inspected eight core services: Urgent and Emergency Care, Medicine (including older people's care, Surgery, Critical Care, Maternity and Gynaecology, Services for Children, End of Life, and Outpatients and Diagnostic Services.

Overall, we rated this hospital as inadequate. The surgery and end of life care services were rated inadequate because of concerns around safety, responsiveness and leadership. We found important improvements had been made in maternity and gynaecology and services for young people since our last inspection. The other four core services were rated as required improvement.

Our key findings were as follows:

Safe:

- There was no dedicated place of safety room in the emergency department for patients with psychiatric conditions.
- Infection prevention and control procedures were not strictly adhered to, increasing the risk of infection for patients. We found poor infection control practice in the surgery service.
- The incident reporting process was inconsistently applied. We found limited evidence of learning from incidents or complaints.
- Staff did not always record actions taken or learning points for incidents. The knowledge of incidents and awareness of shared learning was inconsistent.
- The trust did not provide all patients with one-to-one care during labour which is recommended by the Department of Health.
- Staff had a good understanding of the trust's safeguarding policy and procedures and how to protect patients from abuse. The children's service had good arrangements in place to keep children and young people safe.

Effective:

- The use of clinical audits was inconsistent across the core services. We found that some services were undertaking little auditing to identify improvements they could make to patient care.
- We found that there was good compliance with local and national guidance in the treatment of patients.

Summary of findings

- The hospital participated in the National Care of the Dying Audit in May 2015 and in 2016. The hospital performed worse than the England average in most areas for both audits. The service had been slow to start actions and make changes to improve end of life care for patients.

Caring:

- Most staff were caring and compassionate in their delivery of care.
- Most patients and relatives we spoke with were satisfied with the care and support they received and felt that staff took the time to include them in decisions about their care.
- We found many examples of a lack of compassion towards patients nearing the end of their lives.

Responsive:

- Emergency department performance against the national four hour target for treatment and discharge was well below the national 95% target at around 85%.
- The trust suspended monthly mandatory 18-weeks referral to treatment time (RTT) reporting from September 2014 onwards. This followed the identification of significant data quality concerns relating to the accuracy, completeness and consistency of the RTT patient tracking list.
- The average length of stay at Whipps Cross University Hospital was in line with the England average for both elective and non-elective admissions.
- At trust level the percentage of patients whose operations were cancelled and not treated within 28 days was worse than the England average between the first quarter of 2013/14 to quarter four of 2015/16. However, this had improved from around 30% in quarter three of 2014/15 to around 10% in quarter four of 2015/16.

Well led:

- Changes to the leadership structure of the trust, including at site level, were beginning to make a positive impact on the improvement of standards but the pace was too slow. Most staff spoke optimistically of the new leadership structure.
- Governance and risk management was generally well managed. We observed many good managers who had a clear understanding of the issues they faced in their service areas.
- In some services there was a lack of understanding of the vision and strategy of the whole organisation. Local hospital plans and visions were generally well understood.
- We found pockets of poor culture with evidence of bullying and inequality.
- We were unable to find any areas of outstanding practice at Whipps Cross Hospital.

There were also areas of poor practice where the trust needs to make improvements.

Importantly, the trust must:

- The trust must improve bed management, theatre management and discharge arrangements to facilitate a more effective flow of patients across the hospital and to improve theatre cancellation and delayed discharge rates. This should include improving flow of patients into and out of critical care.
- The trust must improve compliance and awareness of trust infection prevention and control policies and processes to ensure surgical staff do not wear theatre scrubs and clogs outside the operating theatres. Additionally, the trust should review its infection control policies for ensuring infectious patients are effectively and safely managed in ward areas.
- The trust must improve compliance with venous thromboembolism (VTE) assessments.
- The trust must work towards improving the organisational culture to reduce instances of unprofessional behaviours and bullying and ensure all staff feel sufficiently supported by their managers.
- The trust must ensure all patients are treated in a caring and compassionate manner, and ensure their privacy and dignity is maintained.

Summary of findings

- The trust must ensure that patients' pain levels are monitored and acted on appropriately and that pain relief is provided to patients when required.
- The trust must ensure there are sufficient numbers of qualified, skilled and experienced staff employed and deployed to meet the needs of patients. This should include ensuring staff have the right skills to recognise and manage the deteriorating patient.
- The trust must ensure all staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- The trust must ensure governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services. This should capture relevant elements of good governance including an adopting a positive incident reporting culture where learning from incidents is shared with staff and embedded to improve safe care and treatment of patients.
- The trust must ensure staff on the wards receive sufficient handover including patients' infectious status.
- The trust must ensure all patients are screened for malnutrition as required by NICE guidelines.
- The trust must ensure that patients needing urgent referrals or follow up appointments for assessment or treatment are followed up promptly.

In addition the trust should:

- The trust should improve its performance against the national four hour target for treatment and admission/discharge in ED.
- The trust should ensure staff always have access to reliable equipment to minimise potential delay to treatment.
- The trust should ensure mixed-sex accommodation breaches are reported without any delays and as required by NHS England guidance.
- The trust should consider the use of an acuity tool to manage capacity on delivery suite.
- The trust should ensure that the latest version of the 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms are used throughout the hospital.
- The trust should improve access to chaplaincy service to meet people's spiritual and emotional needs.
- The trust should ensure the needs and preferences of patients and their relatives are central to the planning and delivery of care at the hospital.
- The trust should ensure the physical environment is fit for purpose,
- The trust should ensure children with learning disabilities are identified on presentation to the hospital and facilities to support these children improved.
- The trust should ensure patients are fully involved in decisions about their care and treatment.
- The trust should ensure that records are complete, accurate and do not contain variances and discrepancies.
- The trust should improve the availability of medical records and reduce the requirement for the need for temporary notes.
- The trust should implement a systematic approach to the assessment of individual risks to the health, safety and welfare of patients.
- The trust should review medical staffing at night in medical services and nurse staffing on acute assessment unit.
- The trust should ensure care plans reflect the individual needs of patients, with particular focus on those with complex needs.
- The trust should ensure compliance with the Mental Capacity Act (2005) and Deprivation of Liberty safeguards (DoLS).
- The trust should ensure more patients are clinically assessed within the 15 minute national target.
- The trust should ensure nursing staff caring for patients requiring tracheostomy care are sufficiently trained.
- The trust should ensure all staff that provide care and treatment to children have the appropriate training.
- The trust should ensure the emergency theatre is compliant with the surgical safety checklist process.
- The trust should ensure there are effective systems in place to ensure patient records are tracked and available when required.

Summary of findings

- The trust should ensure that timely arrangements are in place to replace ageing diagnostic imaging equipment identified as at risk of failure.

Professor Sir Mike Richards
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Urgent and emergency services

Requires improvement

Rating



Why have we given this rating?

Patients were taking too long to be initially reviewed against the 15 minute target. There were not enough doctors in the department with only 4.5 WTE consultants currently in post, which fell short of the 9.4 WTE consultants they should have. There was no dedicated place of safety room which could be used by patients detained under the Mental Health Act or with psychiatric conditions. Patients received compassionate care and were treated with dignity and respect. Staff provided appropriate emotional support to patient. There was clear and effective leadership at all levels and across all staff groups. There were systems in place to identify and manage risk.

Medical care (including older people's care)

Requires improvement



Infection prevention and control procedures were not strictly adhered to, increasing the risk of infection for patients. Medicines and cleaning fluids were not always stored safely and in line with national guidance. The provision of compassionate care was not consistent and patients' privacy and dignity were not always maintained. Communication with patients and their relatives, particularly relating to discharge was variable in quality and timeliness. A clear management structure and clinical governance framework had been put into place but needed to be further developed to realise the full benefits. A positive culture of reporting and learning from incidents, along with the daily safety huddles and ward safety briefings, facilitated the escalation of concerns and dissemination of learning. Staff completion of mandatory training was good and there was access to clinical support and clinical guidelines based on best practice to enable the development and maintenance of staff knowledge and skills.

Surgery

Inadequate



The incident reporting process was inconsistently applied. We found limited evidence of learning from incidents or complaints.

Summary of findings

Surgical site infection data was not effectively captured and used to inform the service and drive improvement. Surgical services did not have a well embedded working relationship with the infection prevention and control team. There was also poor communication and understanding between the wards, recovery and acute assessment unit in relation to handovers.

Not all patients were screened for malnutrition as required by NICE guidelines.

We saw little evidence that local clinical and quality audits were regularly carried out. Specialist surgical clinical governance meetings (apart from theatres) were not well embedded, and were poorly attended.

We found staff to be committed, dedicated, caring and motivated to deliver care and treatment to patients.

The surgical service worked towards reducing hospital-acquired pressure ulcers with the surgical wards achieving good results.

Patients' pain was assessed and managed effectively.

Critical care

Requires improvement



Staff did not always record actions taken or learning points for incidents. The knowledge of incidents and awareness of shared learning was inconsistent.

Learning points from mortality and morbidity meetings were not consistently followed up.

ICNARC data for April 2015 to December 2015 suggested the unit had higher than expected mortality levels (compared to similar units nationally). Senior staff were not fully aware of the latest ICNARC clinical audit data results.

The unit was failing to comply with a number of the 'London quality standards' for adult critical care.

Not all patients were seen and reviewed by the consultant in clinical charge of the unit at least twice a day, seven days a week.

The acute response team (ART) was not able to provide a 24-hour, seven-day service and plans to provide this cover did not seem sustainable. There was poor oversight of the acute response team as it was not managed within the department and division. The team's activity was not monitored to ensure the team responded to all referrals promptly.

Summary of findings

All staff we spoke with demonstrated a good awareness of policies and how to access them. They had a good understanding of their responsibilities with regards to safeguarding patients from harm or abuse.

Staff worked to meet individual needs, for example through translation services, communication tools, and individualised patient diaries, which were used to record patient's likes and dislikes as well as religious and spiritual beliefs.

Relatives told us the staff were helpful and gave them regular updates and that they felt suitably involved in their loved one's care.

Maternity and gynaecology

Good



Patients and their relatives spoke highly of the care they received in both the maternity and gynaecology services

Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice.

We found all areas of the maternity and gynaecology service we visited to be visibly clean and well maintained.

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

Services for children and young people

Good



Staff members demonstrated and were encouraged to adopt an open and transparent culture about incident reporting.

Patients were safeguarded from the risk of abuse and we saw that staff fully understood how to activate as necessary the trust's local safeguarding policies and could describe national best practice guidance.

Children's services participated in a range of local and national audits, including clinical audits and other monitoring activities.

Nursing staff levels did not always meet national standards in the majority of clinical areas including the neonatal unit.

The environment in which children were cared for within Acorn, the general paediatric ward, was in the main appropriate, although residential accommodation for the parents was basic..

Summary of findings

End of life care

Requires improvement



We observed some patients were visibly in pain, but staff did not respond to this by providing them with adequate analgesia.

There were examples of lack of compassionate care. One patient looked dirty with stains all down the front of their nightwear and staff had neither noticed it nor took any actions to wash and care for the patient.

There was little support provided by the chaplaincy service for people's spiritual and emotional needs. The needs and preferences of patients and their relatives were not central to the planning and delivery of care at this hospital.

The hospital participated in the National Care of the Dying Audit in May 2015 and in 2016. The hospital performed worse than the England average in most areas for both audits. The service had been slow to start actions and make changes to improve end of life care for patients.

End of life care training was provided during induction but there was no mandatory ongoing end of life care training for consultants.

The trust had developed a draft strategy for the end of life. This had not been linked with other services such as therapy services and chaplaincy.

However;

Medicines were stored and managed safely for end of life patients. Records were complete and accessible and enabled information to be accessed to support patients' welfare.

There was access to syringe driver equipment and they were in line with national standards.

Outpatients and diagnostic imaging

Inadequate



Incidents were not always reported or actioned in line with trust policy. Staff and managers had different views on what should be reported and what actions should be taken when incidents were reported.

Risk registers did not reflect all areas of concern. Risks relating to radiology and diagnostic equipment breakdown were on the risk register, however there was no mention of the impact on patients when appointments were cancelled, or co-ordinated systems in place to ensure patients were appropriately re-booked.

Summary of findings

The outpatient department was not tracking all patient health records. The location of medical records was often unknown and resulted in delays or temporary notes being used.

The appointment centre and central booking call centre had a shortage of skilled staff and operating systems that were not working effectively for patients. As a result, patients and staff were often unable to contact the call centre when they needed to.

The trust did not have a robust enough system of audit in place or effective enough means for measuring quality. Reporting turnaround times in radiology and diagnostics were not meeting best practice guidance. Over 25% of radiology and diagnostics patients had not had scans or x-rays reported on within the recommended timescales. We observed a lack of leadership which led to some staff feeling demotivated, high levels of stress and work overload. This resulted in poor cooperation between teams and staff reluctant to raise concerns.

We saw that records were securely stored. Medications that were prescribed were managed safely. In outpatients, radiology medicines were stored in locked cupboards in the department. Lockable medicines fridges were in place, with daily temperature checks recorded.

There was evidence of treatment across outpatient's services that were delivered in line with national guidance and best practice. Staff had access to provision of evidence-based advice, information and guidance. Staff with specialist skills and knowledge supported their colleagues to provide advice or direct support in planning or implementing care. Teams made appropriate referrals on to specialised services to ensure that patients' needs were met.

Whipps Cross University Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Whipps Cross University Hospital	12
Our inspection team	12
How we carried out this inspection	13
Facts and data about Whipps Cross University Hospital	13
Our ratings for this hospital	15
Findings by main service	16
Action we have told the provider to take	193

Background to Whipps Cross University Hospital

Whipps Cross University Hospital in Waltham Forest is part of Barts Health NHS Trust, the largest NHS trust in the country, serving 2.5 million people across Tower Hamlets and surrounding areas of the City of London and East London.

Whipps Cross University Hospital provides a range of general inpatient with 636 beds, outpatient and day-case services, as well as maternity services and a 24-hour Emergency Department and Urgent Care Centre. The hospital has various specialist services, including urology, ENT, audiology, cardiology, colorectal surgery, cancer care and acute stroke care.

Waltham Forest is in the most deprived quintile of local authority districts and about 25.0% (14,500) children live in poverty. The population includes 47.8% BAME residents.

We returned to inspect this location (and the Royal London Hospital location) to follow up on our previous inspection of Barts Health NHS Trust in 2014 and 2015 where we found a number of concerns around patient safety and the quality of care. Following the last inspection, significant changes were made to the leadership of the organisation at both an executive and site based level.

Our inspection team

Our inspection team was led by:

Chair: Ellen Armistead, Deputy Chief Inspector, Care Quality Commission (CQC)

Head of Hospital Inspections: Nick Mulholland, CQC

Inspection Manager: David Harris, CQC

The team included CQC inspectors and a variety of specialist advisors; such as consultants and doctors of different grades; nurses, midwives and allied health professionals, as well as experts by experience. We were also joined by specialists in child and adult safeguarding, clinical governance, executive leadership and work force race equality. An analyst team and an inspection planner also supported the inspection.

Detailed findings

How we carried out this inspection

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

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

Before our inspection, we reviewed a range of information we held and asked other organisations to

share what they knew about the hospital. These included the clinical commissioning groups (CCGs), NHS Improvement (NHSI), Health Education England (HEE), General Medical Council (GMC), Nursing and Midwifery Council (NMC), Royal College of Nursing (RCN), NHS Litigation Authority and local branches of Healthwatch.

We held focus groups with a range of staff in the hospital, including doctors, nurses, midwives, allied health professionals, and non-clinical staff. We interviewed senior members of staff at the hospital and at the trust. A number of staff attended our 'drop in' sessions to talk with a member of the inspection team.

Facts and data about Whipps Cross University Hospital

Context.

The site is located on a large campus situated to the East of London. It is one of 5 hospitals run by Barts Health NHS Trust, the largest trust in the country.

The main commissioner of the acute services is Waltham Forest clinical commissioning group (CCG).

The population of Waltham Forest is statistically worse than the national average for deprivation, under 16s in poverty, statutory homelessness, violent crime, long term unemployment, obese children (year 6), drug misuse, recorded diabetes, incidence of tuberculosis (TB), acute sexually transmitted infections, smoking related deaths, killed and seriously injured on roads, and under 75 mortality rate for cardiovascular and cancer diagnosis.

The population of Waltham Forest is statistically close to the national average for alcohol-specific hospital stays (for under 18s), smoking prevalence, percentage of physically active adults hip fractures in people aged 65 and over, GCSE achieved 5 A*-C, life expectancy at birth (males), and infant mortality.

The population of Waltham Forest is statistically better than the national average for smoking status at time of delivery for women, under 18 conceptions, life expectancy at birth (males), obese adults, excess weight in adults, hospital stays for self-harm, and hospital stays for alcohol related harm.

The hospital has a total of 636 beds – 66 maternity beds and 9 critical care beds.

2. Activity

Inpatient medical admissions: 21,761 (January 2015 – December 2015)

Outpatient appointments: 481,011 (January 2015 – December 2015)

Emergency attendances: 456,149 trust wide, with 197,000 at Whipps Cross Hospital (April 2015– March 2016)

Births: 4,538 (October 2014 – September 2015)

3. Bed occupancy

Equal and above 95% (2015/16).

4. Incidents

Trust wide there were 14 never events and 337 serious incidents (August 2015 – July 2016) Whipps Cross Hospital reported no never events (June 2015 - May 2016).

5. CQC Inspection history

The hospital was last inspected as part of the Bart's Health NHS Trust inspection in January and February 2015 under the CQC's new methodology. Whipps Cross Hospital was rated overall as:

Safe – Inadequate

Detailed findings

Effective – Inadequate

Caring – Requires Improvement

Responsive – Inadequate

Well-led - Inadequate

6. Key Intelligence Indicators

Safe?

One never event was reported at Whipps Cross Hospital between August 2015 and July 2016. Overall, the trust reported 14 never events in the same period.

Between June 2015 and May 2016, the trust reported 337 serious incidents (SI).

Clostridium difficile: 25 cases reported in the hospital between May 2015 and April 2016

MRSA: The hospital has had 5 cases of MRSA between May 2015 and April 2016. It has also had a higher number of MRSA cases per 10,000 bed than the England average since September 2015.

Effective?

Summary Hospital-level Mortality Indicator (SHMI) - no evidence of risk for the trust as a whole.

ICNARC for Whipps Cross University Hospital shows a mixed performance. It is in the top 95% of units for High Risk Sepsis Admissions, the bottom 95% of units for both mortality indicators and in line with other units for the rest of the indicators.

In the heart failure audit 2014 the site scored worse than the England average for three out of four of the in-hospital indicators and five out of the seven discharge indicators.

In the MINAP audit the trust scored worse than the England average for all three indicators. It scored particularly poorly for percentage of patients being admitted to a cardiac unit or ward.

Whipps Cross Hospital performed worse than the England average for 10 of the 17 measures in the 2015 National Diabetes Inpatient Audit.

In the Sentinel Stroke National Audit Programme (SSNAP) the site scored 'B' overall. This is the second best score possible.

Caring?

The hospital had performed poorly in the CQC in patient survey of 2015.

The average Friends and Family score at Whipps Cross Hospital had been around the England average but had deteriorated since February 2016.

Cancer Patient Experience Survey 2015 – The trust was in the bottom 20% nationally for most question in the survey.

Responsive?

Between June 2015 and May 2016 Whipps Cross performed worse than the England average for the percentage of patients being seen within four hours, also failing to meet the 95% national standard for the whole of the reporting period.

Referral-to-treatment times – the trust stopped providing this data beyond August 2014, so no up to date reliable data is available.

The did not attend rates for Whipps Cross University Hospital were consistently above the England average.

The percentage of people with an urgent cancer GP referral seen by specialist within two weeks was better than the England average from Q3 2014/15.

Whipps Cross University Hospital had a low proportion of people waiting 6 plus weeks for diagnostic tests when compared to the England average.

Well led?

Staff survey 2015 overall engagement score (trust as a whole): 3.68. Slightly worse than the England average of 3.79

Across the 32 Key Findings, the trust scored better compared to the national average in 3 key areas and was within expectations in 3 key areas. However, the trust scored below average in 26 key areas.

The trust's sickness absence rate has been below the England average since February 2015

Workforce Race Equality Standard (WRES): Key indicators in 2015 staff survey showed that 80% of white staff against 59% of BAME staff believed that the organisation provides equal opportunities for career progression.

Detailed findings







The NHS staff survey indicated there was a higher proportion of staff reporting the experience of harassment, bullying or abuse in the last 12 months compared to the national average

Our ratings for this hospital

Our ratings for this hospital are:

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

Urgent and emergency services

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

Information about the service

Bart's Health NHS Trust has emergency departments (ED) on three sites; at Royal London Hospital, Newham University Hospital and at Whipps Cross University Hospital. These sites provide a 24-hour, seven days a week service. 460,711 patients attended the ED department on all three sites during 2015/2016. About 18.9% of ED attendances resulted in admission.

The ED at Whipps Cross University Hospital saw about 197,000 patients during the financial year 2015/2016. Approximately 25% of those patients were younger than 16 years old.

There are different areas in ED depending on the severity of the condition of patients. Patients arrive in the department either by walking into the reception area or arriving by ambulance via the ambulance only entrance.

Patients transporting themselves to the department report to the streaming area located inside the entrance of the ED. The streaming area is part of the main reception area in the ED and is run in partnership with the Partnership of East London Co-operatives (PELC). PELC is commissioned by Waltham Forest Clinical Commissioning Group. Patients are assessed and streamed in accordance with their clinical need and are booked in by reception staff to the relevant area of the ED.

There was a resuscitation unit which had six beds, commonly known as 'resus', for patients with immediately life threatening illnesses and injuries. The

'majors' area, for patients with acute illnesses and rooms which could be used to isolate patients or to provide privacy. There is a separate paediatric area for children and young people under the age of 16.

There is an area for treating low risk patients whose condition is not life threatening, called 'minors'. It has cubicles, a triage room, a plaster room and treatment rooms.

Patients attending the ED should expect to be assessed and admitted, transferred or discharged within a four-hour period in line with the national target. If an immediate decision cannot be reached, a patient may be transferred to the Clinical Decision Unit (CDU) for up to 12 hours or admitted to the Acute Assessment Unit (AAU), for up to 48 hours. The AAU formed part of the medical speciality.

During our inspection, we spoke with 52 members of staff including ED nurses, ED consultants, junior doctors and nurses, paediatric registrars, clinical nurse educator, emergency care assistants, local managers, specialist CAMHS nurse, and radiographers amongst other members of staff. We also spoke with 29 adult and child patients, and some of their relatives. We examined 22 sets of medical notes for patients treated in the department.

Urgent and emergency services

Summary of findings

Overall we rated this service as requires improvement because;

- Patients were taking too long to be initially reviewed against the 15 minute target with assessment times varying between 33 and 42 minutes. This meant patients were at risk of deteriorating before being diagnosed and treatment started.
- There were not enough doctors in the department with 6.45 general ED consultants and two paediatric ED consultants (WTE) in post. The department fell short of the 9.4 WTE consultants they should have. 40% of middle grade medical shifts were filled by locum staff who were on short term contracts.
- There was no dedicated place of safety room which could be used by patients detained under the Mental Health Act or with mental health conditions. The ED environment was not suitable to meet needs of patients waiting to undergo mental health assessments.
- Performance against the national 4 hours target for treatment and discharge was well below the national 95% target at around 85%.
- There was no long term strategy for the future role of the ED within the trust's overall strategy.

However;

- Medicines were managed safely and staff were well trained and experienced in safeguarding patients from abuse.
- Care was provided in line with national best practice guidelines. The ED participated in a comprehensive set of audits with evidence that they learnt from them.
- Patients were not always informed about the progress of their case or the reasons for any delays.
- Patients with specific need such as learning disability or dementia were taken into account in the planning and delivery of the service.
- Patients received compassionate care and were treated with dignity and respect. Staff provided appropriate emotional support to patients.

- There was clear and effective leadership at all levels and across all staff groups. There were systems in place to identify and manage risk.

Urgent and emergency services

Are urgent and emergency services safe?

Requires improvement



We rated safe as requires improvement because:

- Patients were taking too long to be initially reviewed against the 15 minute target with assessment times varying between 33 and 42 minutes. This meant patients were at risk of deteriorating before treatment started.
- Many children in ED were not triaged within the 15 minutes. Nurses in children's ED said they were worried about the volume of patients, as they did not feel they had sufficient resources in terms of staff numbers and space to cope.
- The use of national early warning scores (NEWS) to identify deteriorating patients was not consistent in the department. The ED did not audit how well staff used this tool.
- There were not enough doctors in the department with 6.45 general ED consultants and two paediatric ED consultants (WTE) in post. The department fell short of the 9.4 WTE consultants they should have. 40% of middle grade medical shifts were filled by locum staff who were on short term contracts.
- There was no dedicated place of safety room which could be used by patients detained under the Mental Health Act. The ED environment was not suitable to meet needs of patients waiting to undergo mental health assessment.

However:

- The ED had a robust process for ensuring that clinical incidents were reported and investigated. Staff were aware of their responsibilities to report incidents and be open with patients in the event that things go wrong.
- The measures for the prevention and control of infection met national guidelines and the standards of hand washing were consistently high.
- There were good medicines management practices in place and drugs were administered and stored safely.
- The ED had a good emphasis on safeguarding for both children and adults. Staff were well trained and knew the correct procedures to follow should they have concerns.

Incidents

- Whipps Cross Hospital ED reported no never events between June 2015 and May 2016. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff were aware of trust wide systems to report and record safety incidents and near misses. Incidents were shared through regular formal meetings and daily briefings. There were additional monthly meetings where incidents were discussed.
- Nurses in children's ED told us serious incidents were very rare. They were familiar with the electronic incident reporting system and were able to give examples of when they used it.
- The acute medicine and emergency care department reported a total of 532 incidents via the electronic incident reporting system between January and April 2016.
- Between August 2015 and July 2016 there were seven serious incidents reported through the Strategic Executive Information System (STEIS). One incident related to a pressure ulcer, one related to safeguarding adults, and a further incident related to a deceased patient left in ED inappropriately overnight contrary to department policy. There were four incidents of poor care which resulted in each case in a potentially avoidable patient death. In each case there was a delay in either assessing, diagnosing or escalating a deteriorating patient. Only one of these serious incident investigations was concluded at the time of the inspection. The others were still undergoing root cause analysis. Staff were aware of these serious incidents and had discussed them at staff briefings.
- The emergency department held mortality and morbidity (M&M) meetings on a monthly basis. A member of the clinical effectiveness unit and a representative attended the meetings from the patient panel, as well as ED doctors and a practice development nurse. We noted that no learning points had so far been identified from M&M meetings held in 2016 (January to May). The team discussed deaths and complex cases treated within the ED and management stored the brief notes from discussions held.

Urgent and emergency services

- The trust reported two falls and one catheter urinary tract infection between 2015/2016 for the ED.
- The acute assessment unit undertook monthly audits of urinary catheter care to prevent cross contamination and infections. Audits recorded 100% compliance with the required care standard.
- They also undertook peripheral vascular catheter insertion (cannulation) and care audits which indicated 100% compliance. These were completed monthly in 2015/16 to ensure standards were maintained and any possibility of complications were minimised. However, staff in the ED did not complete all these insertion audits monthly as required by trust policy and procedures. Of the eight audits undertaken in 2015/2016, all indicated 100% compliance with the required standard.

Cleanliness and infection control

- We saw that the whole department was visibly clean. Cleaners were present in the department from 6am until 10am and in the evening from 10pm to 2am. Cleaners were available to empty bins throughout the day.
- Results from the 2015 Patient-Led Assessments of the Care Environment (PLACE) programme indicated that the ED areas were clean, achieving a score of 100% which was slightly better than the national average (98%). These self-assessments were undertaken by teams of NHS and independent health care providers. At least 50% of each team was made up of members of the public.
- Monthly hand hygiene audits, when undertaken, indicated that ED staff followed the trust policy, with compliance recorded as 100% for seven months of 2015/16. However, these audits were not undertaken monthly as prescribed by the trust's policy and procedures. Audits undertaken within acute assessment unit (AAU) were completed on a monthly basis and indicated 100% compliance.
- Most of the patients at the AAU were screened for presence of the MRSA bacteria. The hospital monitored screening compliance rates and they varied between 70% and 100% from October 2015 to April 2016. Overall,

these results were better than the average for the hospital (between 71% and 85% for the surgery and medical care divisions). None of the 11 MRSA cases recorded by the hospital in 2015/16 occurred in the ED.

- None of the 23 C. difficile cases reported within the Whipps Cross Hospital in 2015/16 occurred in the ED.
- Environmental audits were undertaken quarterly, by the infection and prevention control team, for each of the areas of the ED. Each audit included checking if waste was managed correctly, monitoring hand hygiene compliance and establishing overall cleanliness levels. The scores recorded in May 2016 were low; the resuscitation area scored only 52% compliance and the minors area scored 50%. The majors area, although audited, was not scored by the auditor. Numerous areas where improvement was required were highlighted through these audits including: lack of cleaning schedules and checklists, unavailability of hand sanitisers at the point of care, dirty hand washing basins, dust on surfaces, dirty bedsides and monitoring equipment and staff not adhering to the dress code policy. The department was in the process of delivering action plan in response to findings of these audits.
- The hospital reported delays in identifying and treating patients with severe sepsis in 2014/2015. The department held training sessions in ED and members of the team completed a quality improvement patient safety programme. A sepsis screening tool was introduced to identify patients with severe sepsis. Sepsis trolleys, with all the necessary equipment and paperwork in one place, were made available to staff. As a result, the department reported that 23% more patients received antibiotics within 1 hour in a recent audit (90% in December 2015).
- The accident and emergency survey 2014 indicated that trust performed about the same as other trusts for measures related to cleanness of the department.

Environment and equipment

- There were five cubicles in the paediatric ED and an additional five-bedded clinical area called the 'Flamingo area'.
- We noted that most of the equipment used was tested and calibrated to ensure it was safe to use. This included electronic thermometers, parameters

Urgent and emergency services

monitors, and nebulisers. However, on some of the blood pressure monitoring equipment in treatment rooms there were no indications of checks being undertaken by staff. There was also no evidence that the ultrasonography equipment used in ED for gynaecology patients was regularly serviced as there were no labels present to indicate this. After our inspection, the trust did send us records of checks that demonstrated this equipment was safe to use. There was a system which allowed tracing checks and emergency repairs to be undertaken on equipment if necessary.

- There were two x-ray machines dedicated for use by ED patients. Staff had frequent problems with them as they were over nine years old. A member of staff described one occasion when both machines were out of order at the same time. There was service agreement in place to fix any issues and staff said the service was responsive. This was included on the local risk register and the trust was looking into replacing both x-ray machines.
- The emergency department facilities were generally compliant with the relevant Health Building Notice (HBN 15.01) requirements as the main ED building was opened in 2012. The building was designed to comply with the HBN that was current at the time.
- Patient-led assessment of the care environment (PLACE) was carried out annually with an aim to improve standards. Results from the 2016 audit indicated that ED areas were in good condition and were maintained well. The ED department achieved an overall score of 97%, which was better than both the hospital and national average (93%).
- There was no dedicated place of safety room which could be used by patients detained under the Mental Health Act. The ED environment was not suitable to meet needs of patients waiting to undergo mental health assessment.

Medicines

- Resuscitation trolleys we examined contained appropriate equipment and were compliant with standards. We examined a range of equipment such as airways tubing, syringes, dressing towels and intravenous canulae and all were in date.

- Medication was managed correctly overall. However, there was no record to indicate the fridge temperature was checked regularly to ensure it was within the safe range for the storage of medication.

Records

- We reviewed children's records and noted that the time of triage review was not always documented. All other relevant information related to treatment and decisions taken was included.

Safeguarding

- There was good emphasis on safeguarding and the nurses we spoke with were all familiar with the safeguarding processes.
- Nurses we spoke with were fully aware of female genital mutilation (FGM) and child sexual exploitation issues.
- Records indicated that all staff working within children department completed level 3 safeguarding training. In addition, all ED staff completed level 1 and 2 safeguarding refresher training in 2015/16.
- Senior managers said safeguarding measures were fully embedded within the service and that children were 'yellow flagged' as required on the safeguarding register (yellow flag was used on the electronic patients record system to highlight a child at risk). The links with the safeguarding team were robust.

Mandatory training

- There was a practice development nurse for the emergency department. Their main role was to co-ordinate mandatory and statutory training (MAST) for nursing staff, healthcare assistants and student nurses.
- There were 19 paediatric ED staff in total. Five of them did not complete fire safety training and six did not receive moving and handling training. The majority of staff (18) completed infection control training and medicine management training. These were also provided with training related to security.
- Staff were equipped with a MAST training booklet, training manual and annual update booklet. It covered training areas staff were expected to keep up to date with.
- Management monitored the MAST compliance at the 8am daily morning safety meetings.. Also, the practice

Urgent and emergency services

development nurse reminded all staff to complete their MAST. Copies of any completed training booklets were forwarded to the central trust database via email. Staff told us the monitoring system worked well and there was sufficient oversight to ensure all staff were provided with relevant training.

Assessing and responding to patients risk

- The average time to initial assessment of patients who arrived in an ambulance varied between 33 and 42 minutes between May 2015 and May 2016, against a national target of 15 minutes. It was notably worse that the England average of five to seven minutes. Overall 60% to 72% of journeys had ambulance turnaround times of over 30 minutes. There were between 103 and 251 ambulance journeys each month with turnaround times of over 60 minutes with February 2016 recorded as the worst month.
 - The average time to treatment for all patients were recorded between 79-100 minutes in the same period. It was also worse than the England average (55-60 minutes) in every month between May 2015 and May 2016. Whipps Cross failed to meet the 60 minute standard for time to treatment during the entire reporting period, recording an average of 90 minutes for time to treatment.
 - There were 517 delays (over 30 minutes) in handovers from ambulance to ED staff recorded by the hospital between November 2015 and March 2016. This meant that staff were not always able to assess patients risk and provide treatment in a timely manner.
 - There was an increase in the number of plus 60 minute offloading incidents ('black breaches') between December 2015 and March 2016, corresponding with the seasonal increase in ED attendances. The number of breaches was high particularly in February where 23 black breaches were recorded. We noted a 15% increase in attendance levels for that month. The majority of black breaches (51.4%) during the reporting period cited limited bed capacity as the primary reason. Most black breaches had more than one reason for the breach, with bed capacity being mentioned in 92% of explanations and staff shortages in 81%.
 - Use of national early warning scores (NEWS) to identify deteriorating patients was not consistent within the department. They did not audit how staff used this tool.
- ED carried out a post-inspection audit, which sampled 30 patients who attended ED between April and May 2016. The audit found that each NEWS score was clinically indicated and correctly calculated. Patients had their NEWS recorded in their notes, alongside appropriate actions. These included hourly observations, transfers to resuscitation areas and appropriate escalation. The trust audit reported that the "majority of patients had a further NEWS recorded". Of the sample, two patients did not have any NEWS recorded. One of these patients had an isolated and non-serious ankle injury, and the other was a mental health patient who refused any observations to be taken.
- Nurses told us that only 80% of children were triaged within the 15 minutes. We reviewed patients' notes of those who were treated on the day of inspection. Only one of these children was not triaged within 15 minutes. Nurses in children's ED said they were worried about the volume of patients, as they did not feel they had sufficient resources in terms of staff numbers and space to cope.
 - Although sepsis six (a bundle of medical therapies designed to reduce the mortality of patients with sepsis) was not used within the children's ED, we saw a fever management protocol. The use of the paediatric early warning scoring (PEWS) system was well documented and the SBAR (situation-background-assessment-recommendation) form of communication was used informally. PEWS formed a fundamental part of the triage process. Nurses told us safety monitoring was consistent and that pain scoring tools were always used.
 - The vast majority of nurses in the paediatric department were trained children's nurses. Normally there were five paediatric-trained nurses per shift but in the winter there were only three, which the nurses found challenging and told us "it felt unsafe".
 - The registrars told us the children's ambulance retrieval service worked well and that children requiring transfer to the paediatric intensive care unit (PICU) were appropriately cared for until ambulance's arrival.
 - Nursing staff completed paediatric intensive life support training annually.
 - Junior doctors only received basic life support training.

Urgent and emergency services

Nursing staffing

- Staff felt there were enough nurses on duty most of the time; however we noted a high use of bank staff, particularly on night shifts. One of the ED nurses told us the children's ED was overly reliant on the use of agency nurses to cover shifts. All agency nurses were trained children's nurses. Records indicated bank staff covered 33% to 39% of all nurses' shifts in 2015/2016.
- The nursing roster for February 2016 indicated that 73 out of 84 shifts during this period relied on bank or agency nurses.
- The trust analysed patients' attendance and activity levels to help inform staffing levels. There were between 19 and 27 nursing staff present each day. The highest number of nurses were scheduled to work between 2pm and 7pm. It did not directly correlate with the highest ED attendance levels, which peaked between 1pm and midnight.
- Acuity modelling in ED was undertaken using both the 'baseline emergency staffing tool' and senior manager's professional judgement. The tool required data to be collected for a seven-day period on an hour-by-hour basis. The department also used a tool which measured patients' dependency to establish the total number of staff on shift in the department. There was approximately one registered nurse allocated to four patients in majors' area. Within the resuscitation room one nurse was allocated to 2.5 patients and the ratio in the clinical decision unit was one nurse to 4.5 patients. Within the acute assessment unit one nurse was responsible for six patients.
- Records indicated that 29% of nursing posts were vacant in the main ED department. A further 9% were vacant within the children's department, which included the urgent and emergency care unit (2015/16). The average hospital vacancy rate was 11%.
- The sickness rate for ED was 4% among nurses and 11% among healthcare assistants in 2015/16. The average hospital sickness rate for the same period was 4.8%.
- In Paediatrics shifts were 12 hours long and there were two shifts per day. Three nurses were on duty at one any

time, supported by one additional healthcare assistant. Additionally there was a twilight shift, which provided one extra trained nurse to cover the department from 6pm until 2am.

- Junior nurses were recruited and in the process of completing their preceptorships. Management allocated a senior nurse to support them during the course of their preceptorships.
- A nurse we spoke with told us there were staffing shortages, especially in the winter period. This was reflected in service delivery and meant that the 15-minute triage window was often breached. Staff told us staffing levels improved in weeks prior the inspection.
- Nurses felt that there were not enough paediatric doctors. There were two senior nurses, which made up 1.5 whole time equivalent (WTE) posts. One of these nurses was trained as an emergency nurse practitioner.

Medical staffing

- There were 6.45 general ED consultants and two paediatric ED consultants (WTE) in post. The department fell short of the 9.4 WTE consultants they should have. The record provided by the trust did not indicate there were any vacant posts. However, records did show that between 30% and 40% of shifts were filled by locums in 2015/16.
- There were two dedicated paediatric ED consultants.
- Staff confirmed that around 40% of middle grade medical shifts were filled by locum staff. Half of these locums were on three-month contracts. The trust had a system for locum induction and involved them in mandatory trust training.
- There was 16 hours of face-to-face consultant cover each day. Staff felt this was adequate to meet patients' needs.
- The analysis of patients' attendance and activity levels indicated that medical cover was partially adjusted in response to demand. There were between five and 21 doctors present at the ED department each weekday and five to 13 on weekends. Patients' attendance peaked between 1pm and midnight each day. Records indicated between 12pm and 6pm there was an average

Urgent and emergency services

of 16 to 21 doctors, with 12 doctors working between 6pm and midnight. There were only six doctors working during the night where patients' attendance levels were lower.

- There was a consultant paediatrician present daily from 8.30am to 4.30pm. They were supported by a paediatric emergency medicine doctor who provided cover 8am to 4pm, and doctors from ED medical team working at the paediatric ED on rotational basis. The consultant paediatric rota for April 2016 indicated that on-call cover was provided between 4.30pm and 8.30pm. Records indicated lower use of locum doctors within the children's department (between 2-10% in 2015/16).
- Plans to open a clinical decision unit as part of the children's ED were well advanced. However, staff told us the department was struggling to recruit and sustain adequate levels of staff.
- Records for 2015/2016 indicated low sickness rates among doctors, below 1%. This was in line with the hospital average for doctors (0.4%).

Major Incident planning

- Major incident plans were updated since the Olympic Games, when the hospital was designated as a 'decontamination centre'. The major incident plan, issued in April 2015, indicated responsibilities for all staff and included flow charts informing staff how to proceed should any untoward incident occur. A consultant on duty was responsible for overseeing the management and medical response of the ED, and for co-ordinating the staff and resources within this area. The matron was expected to support them and the nursing staff. The resuscitation area team leader and the anaesthetics commander were to review and prioritise resus patients for surgery and communicate with the theatre co-ordinator.
- The major incident plan for the hospital was incomplete as it did not contain (although indicated in the content section) information relating to the training programme or exercise programme. It was therefore unclear what was expected from the ED in these areas.

Are urgent and emergency services effective?

(for example, treatment is effective)

Good



We rated effective as good because:

- Staff provided care in line with national best practice guidelines. We observed staff accessing NICE and local guidelines for example sepsis on the trust intranet.
- We observed that staff offered pain relief to patients. Patients told us staff asked about their medication preference and if they were in pain.
- The ED participated in a comprehensive set of audits with mixed performance. There was evidence of some learning and improvement from these audits.
- There was a preceptorship programme for all newly qualified nurses and a special preceptorship model for European Nurses (for example, nurses from Spain and Portugal). Management allocated each new nurse to a mentor. There was a practice development nurse who sourced a special paediatric orientated preceptorship course at the Royal London Hospital which the Whipps Cross ED nurses attended.
- Staff asked patient for their consent before being treated and we saw evidence of signed consent forms. Staff understood the principles of the Mental Capacity Act 2005 and Deprivation of Liberties Safeguards (DoLS).

However:

- The department participated in the RCEM audit of Older People in ED 2014/15. Outcomes indicated that not all patients over 75 years old were screened for dementia as advised by the RCEM with only 6% of people being screened.
- Multidisciplinary team (MDT) working with other professionals and departments was poor. Although there were monthly meetings between ED and radiology team, there were some ongoing conflicts, which potentially affected care delivery. Apart from handovers there were no regular MDT meetings within the children's ED department. Nurses we spoke with said there was limited MDT working.

Evidence based care and treatment

- The emergency department participated in a number of national audits, for example the Royal College of

Urgent and emergency services

Emergency Medicine audits. The newly appointed clinical director was working with the ED leadership team to ensure that the local audit programme supported improvements through learning from thematic reviews of complaints, incidents and risks.

- National and National Institute for Health and Care Excellence (NICE) guidelines were being followed and staff were able to access them. This included sepsis guidelines which were followed adequately within the main ED.
- Staff accessed all protocols and national guidelines via the trust intranet and those we examined were in date. The registrars told us they were easy to access and staff could access them via their mobile phones.
- We analysed the diabetes and hypoglycaemia guidelines used by the department and these were up-to-date and reflective of evidence-based practice as recommended by national guidance.

Pain relief

- We observed that pain relief was offered to patients. Patients told us they staff asked about their preference of medication and whether they were in pain.
- Children's ED used smiley faces or another visual scale to indicate patient's pain score. Staff used FLACC (Face, Legs, Activity, Cry, Consolability scale) when appropriate and analgesia was administered accordingly.
- The accident and emergency survey 2014 indicated that trust performed about the same as other trusts for measures related to pain control. It related to staff doing 'everything they could' to help control pain, and to the time from pain relief medication request to the time it was administered.

Nutrition and hydration

- The nurses we spoke with told us food and drink was available for children and that squash and snack boxes were available at all times (yoghurt, sandwiches, crisps and other snacks). Tea and coffee were available for parents.
- We observed that staff offered hot drinks and snacks to patients from a drinks trolley every two hours. However, staff did not record fluid intake patients' notes.

- The accident and emergency survey 2014 indicated that trust performed about the same as other trusts for measures related to patients being able to get suitable food or drinks when in ED.

Patient outcomes

- Whipps Cross University Hospital performed better than the England average for the unplanned re-attendance rate to ED within seven days, although they were worse than the 5% standard for the majority of the time period (June 2015 to May 2016). The site showed some improvement from January 2016, since which time they mostly met the 5% standard.
- The hospital participated in the fitting child 2014/15 clinical audit and staff were aware of the results. The ED performed better than the England average for one out of the five measures audited and was within the average for the other four. The audit indicated staff managed all children who were experiencing a fit on arrival appropriately, taking an eyewitness history to ascertain possible causes and documenting this in the patient's clinical record. They also checked the blood glucose levels of actively fitting children (100% compliance for all three standards). However, parent information leaflets regarding safe future management were not always given to parents/carers when children were discharged from the ED (provided in only 19% of cases). As a result, an action plan to revise this leaflet was put into place.
- The department participated in the Royal College of Emergency Medicine (RCEM) clinical audit of Mental Health in ED 2014/15. The hospital performed better than the England average for four out of 11 standards, and worse than expected for only one of the measures. Outcomes of this audit indicated that the one-hour response time was not adhered to (0%). The proforma used to assess mental health patients was used only in some cases (58%) to clearly indicate response times, help clinical staff structure assessments and allow information sharing through the electronic record systems. In only 28% of cases was there a record of follow-up arrangements or details of any onward referral. The proforma clearly needed to be updated. The action plan updated in May 2016 indicated that only three out of six actions have been achieved.

Urgent and emergency services

- The department participated in the RCEM audit of Older People in ED 2014/15. Outcomes indicated that not all patients over 75 years old were screened for dementia as advised by the RCEM (only 6% underwent screening). Staff were instructed to undertake cognitive assessment for all patients over 75 and record it on the ED electronic patients' record system. There was a generic action plan prepared in response to recommendations made. The hospital performed better than the England average in three out of six measures, and in line with the average for the remaining three measures.
- The hospital participated in the vital signs in children clinical audit 2015/16 organised by the RCEM.
- The department contributed to the procedural sedation in adults clinical audit 2015/16 and the VTE risk in lower limb immobilisation in plaster cast clinical audit 2015/16.
- The department contributed to the patient reported experience measure (PREM) for urgent and emergency care. This audit measures the experience of paediatric patients in all emergency care settings and it is organised by the Royal College of Paediatrics and Child Health. The report was awaiting publication at the time of the inspection, and so we were unable to report on these outcomes.
- The hospital participated in the national trauma peer review (NTPR) programme in 2015. This review involved self-assessment, as well as an external review, against nationally agreed quality measures. The review highlighted there was no designated specialty under which trauma patients could be admitted. This led to 'orphaned patients', i.e. patients without a designated specialty consultant. On a number of occasions the ED consultant was required to intervene whilst the patient remained in the department until an appropriate specialty was identified and accepted the patient. The major trauma lead clinician had no time allocated in their job plan to perform this role. The reviewers felt that this, together with the lack of onsite managerial support, was limiting the organisation's ability to develop the trauma service. There was also a lack of formal written pathways, with a reliance on the clinical trauma lead's knowledge. The trust developed an action

plan, which addressed training needs including advanced trauma life support training. It indicated that the trauma lead post was vacant and pathways and clinical guidelines were still to be formally approved.

Competent Staff

- There was a preceptorship programme for all newly qualified nurses and a special preceptorship model for European Nurses (for example, nurses from Spain and Portugal). Each new nurse was allocated a mentor. There was a practice development nurse who sourced a special paediatric orientated preceptorship course at the Royal London Hospital which the Whipps Cross ED nurses attended. A paediatric ED triage course formed part of this programme, which covered all the pertinent aspects of triage for sick children including mental health assessment.
- The trust offered a range of learning opportunities for trained children's nurses including: mentoring, clinical leadership, research, progression to a top-up degree, an acutely ill child course, post-graduate opportunities, advanced paediatric life support (APLS) and paediatric trauma courses. Regular study days were also organised. For example, the department facilitated a study day dedicated to awareness of tuberculosis.
- Management monitored staff performance through annual appraisals. When nursing staff were struggling, either during or post preceptorship, they were supported by the practice development nurse who worked with them on a one-to-one basis. For example, if a drug error occurred, the practice development nurse would complete a root cause analysis (RCA) with the responsible nurse.
- All paediatricians had APLS training; there was also a consultant who had a special interest in sick children. Most of the paediatric registrars had APLS qualifications.
- There was also a paediatric nurse who completed APLS training.

Multidisciplinary working

- Multidisciplinary team (MDT) working with other professionals and departments was poor. Although there were monthly meetings between ED and radiology team, there were some ongoing conflicts, which

Urgent and emergency services

potentially affected care delivery. These related to doctors not providing sufficient information related to medical grounds for scans or not fully following the referral process.

- Staff shared information with external professionals who were involved in the children's treatment. Children and their main carer had a discharge letter sent to their local GP via email and were also given a copy of it before leaving the department. Referrals to a paediatric community nurse could also be arranged.
- Apart from handovers there were no regular MDT meetings within the children's ED department. Nurses we spoke with said there was limited MDT working.
- A specialist mental health nurse supported the children's ED. The child and adolescent mental Health service (CAMHS) employed the specialist nurse to offer a 9am to 5pm service for children admitted to the ED with psychiatric or emotional problems. This nurse saw any patient less than 18 years of age. The nurse was contactable via bleep and they normally responded in less than one hour. The nurse handed over to a duty psychiatrist who provided out of hours support. The nurses in the ED were highly complementary about this service.

Seven Day Services

- The pharmacy was open 9am to 5pm on weekdays and between 9am and 2pm on Saturday. No service was provided on Sunday and patients were advised to use their local pharmacy should there be a need to do so.
- Young people had access to CAHMS service from 9am to 5pm on weekdays.
- There was overnight on-call consultant cover between 10pm and 8am. There were three registrar doctors working at the department 10pm to 7am which included minimum of one senior registrar. Two junior doctors supported them.
- Paediatric ED was staffed with paediatric registrar doctors 8.30pm to 8.30am who had on-call paediatrician consultant support available to them.

Access to Information

- Staff we spoke with told us they had access to the relevant information in order to provide effective care and treat patients in an individualised and timely manner. The number of computers we saw in the ED evidenced this.
- Staff had access to patient and trust information via the computers on the wards.
- Staff had access to an online learning management system and trust policies and protocols via the trust intranet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We were told by the nurses we spoke with that consent procedures were fully embedded into everyday practice. Nurses understood tools used to assess children's capacity to consent, such as the Gillick competency requirements.

Are urgent and emergency services caring?

Good



We rated caring as good because:

- Patients received compassionate care by staff and were treated with dignity and respect. We observed staff being friendly and polite towards patients and visitors.
- Staff provided emotional support and the breaking of bad news was handled in a sensitive manner.
- The ED had carried out its own survey which had shown an increase in patients' satisfaction.
- The ED scored well in the national Friends and Family patient survey.

However:

- Staff were not informing patients about the progress of their case or the reasons for any delays.
- Results from the 2016 Patient-led assessments of the care environment (PLACE) programme indicated that patients' privacy, dignity and wellbeing were not always maintained. The ED score scored 37.5%, which was significantly worse than the national average of 86% and the hospital's average of 80%.

Compassionate care

Urgent and emergency services

- Despite the long waiting times in ED, only four of the 48 patients we spoke with raised concerns about the care they received. We observed that staff were kind and caring towards patients. However we did not observe staff undertaking regular comfort rounds, to ensure people were warm, comfortable and safe.
- One patient told us, “very good experience so far” and another said, “very smooth and everyone very helpful”.
- Between May 2015 and April 2016, the friends and family test (FFT) recommendation rate was generally higher for this site than the England average, with 97% of patients recommending Whipps Cross in January 2016.
- Results from the 2016 Patient-led assessments of the care environment (PLACE) programme indicated that staff did not always maintain patients’ privacy, dignity and wellbeing within ED areas. The department achieved a score of 37.5%, which was significantly worse than the national average (86%) and the hospital’s average (80%). The trust was in the process of preparing an action plan in response to findings of the PLACE assessment.
- The hospital carried out a patient survey which consisted of questions relating to patients’ comfort, dignity and respect, information provision, staff kindness and understanding and patient involvement. The April 2016 survey indicated that the acute assessment unit scored 4.69 (out of five stars) overall. This result was slightly better than the mean average for the previous six months (4.55). The emergency department scored 4.71 In April 2016, which again was slightly better than the average over the previous six months (4.64). Although these results were better than the average hospital score (4.65), we noted that the participation rate was low, with only 2.8% of all patients responding to the survey.

Understanding and involvement of patients and those close to them

- Patients we spoke with in the adult ED felt that they were not always kept up to date on the progress of their case. One person told us, “it’s a waiting game, you just wait until they come and tell you what is happening”, another said, “I am not sure what is going on to be honest”.

- Parents accompanying their children in the children’s ED were positive about the treatment their children received. They said the nurses and doctors understood them and were supportive.
- Parents commented positively on the knowledge of the staff treating their children.

Emotional support

- Although the paediatric ED did not employ a play specialist within the department, the main paediatric inpatient ward could supply one if needed. For example, if a child had a learning disability or needle phobia, a play specialist would be made available.
- We saw that the clinical area of the children’s ED was equipped with a starlight distraction box. These boxes were filled with toys, games, and puzzles to help children cope with various medical procedures. Nurses and play specialists used the distraction materials alike.
- We visited the generic bereavement suite. Whilst visibly clean, it was a stark room and in need of decoration.
- If a child died in ED, support was available for staff who could discuss the events with a senior member of the team and a counsellor.

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

Requires improvement



We rated responsive as requires improvement because:

- The current environment was not responsive to the needs of patients with mental health conditions. There was no specific room available where these patients could wait and be assessed.
- PLACE assessment indicated that some improvements could be made to improve the environment for those with mobility difficulties.
- The trust produced daily bulletin dashboards which demonstrated how ED performed in relation to the four hours decision to admit target. Records indicated that 84.2% of patients attending ED were admitted within

Urgent and emergency services

four hours in 2015/2016. We noted that the hospital reached the target for only one month between April 2014 and March 2016. They performed worse overall in 2015/16 than in the previous year.

However;

- The department was responding to most complaints within the agreed period and staff we spoke with were able to tell us about any learning and changes implemented because complaints.
- Children with learning disabilities who attended the ED were dealt with through the neurological 'l'pathway' for CAMHS. There was a specialist mental health nurse who supported the children's ED. The specialist nurse was available from 9am to 5pm weekdays for children with psychiatric or emotional concerns.
- Patient-led assessments of the care environment (PLACE) 2016 indicated that the general experience for patients' living with dementia that used ED was good. The department scored 83% for this measure, which was better than both the hospital average (71%) and the national average (79%).

Service planning and delivery to meet the needs of local people

- Families in children's ED told us facilities were good, with a breastfeeding room available on request.
- The children's ED waiting room was functional but quite sparse. There was a television and a separate play area.
- The trust has established an Emergency Care Improvement Board chaired by a senior trust manager. The board has identified a number of key areas for improvement and has plans in place to deliver changes. The key target was to reach the 4 hours/95% standard by March 2017.

Meeting people's individual needs

- The ED used a telephone service for translation, complemented by bilingual staff members when available.
- Nurses told us children with a learning disability or autism were well managed "with a flow chart". There is a flagging system on the patient management IT system to ensure patients with learning disability needs were identified.

- Alternative forms of communication, such as Makaton and picture exchange system (PECS), were not commonly used but some of the nurses knew how to use these. The staff had access to a booklet which supported communication with children with communication difficulties.
- We saw a range of information leaflets which were available to patients and their relatives. For example, there was information relating to, febrile convulsions or wrist fractures.
- Patient-led assessments of the care environment (PLACE) 2016 indicated that the general experience for patients' living with dementia that used ED was good. The department scored 83% for this measure, which was better than both the hospital average (71%) and the national average (79%).
- However, the same PLACE assessment indicated that some improvements could be made to improve the environment for those with mobility difficulties. ED scored 67% for this measure, which was worse than both the hospital average (73%) and the national average (81%). The trust was in the process of preparing an action plan in response to this finding.

Access and Flow

- During our July inspection a new provider had just started a contract to provide urgent care centre services and to 'stream' patients who walked into the ED. A clinician quickly assessed patients on arrival and allocated them to the most appropriate treatment pathway, either the UCC or main ED.
- Patients received a white, green, blue or red card so that they were clear which pathway they were allocated. There were also concise information leaflets setting out to patients their journey for example describing diagnosis treatment and discharge. There were children versions with clear words and pictures to aid understanding.
- A senior nurse initially assessed patients arriving by ambulance by taking their vital signs. Patients were given a NEWS score that decided how quickly a doctor then saw them.
- The department held two hourly 'sit rep' meeting attended by the nurse in charge, consultant in charge site manager to ensure that flow is managed effectively.

Urgent and emergency services

- About 18.9% of all trusts ED attendances resulted in admission which was lower than the England average of 22.2%.
- The trust produced daily bulletin dashboards which demonstrated how ED performed in relation to the four hours decision to admit target. Records indicated that 84.2% of patients attending ED were admitted within four hours in 2015/2016. This was worse than the trust average of 88%. We noted that the hospital reached the target for only one month between April 2014 and March 2016. They performed worse overall in 2015/16 than in the previous year.
- The trust introduced initiatives aimed at reducing admission rates and length of stay of patients who presented at ED. For example, if they required regular observation for a time, or were awaiting test results. Patients could be observed for a maximum time of 24 hours at the CDU. There was a list of exclusion criteria for the CDU, which included: patients who were unlikely to be discharged within 24 hours, patients who were aged over 75, or patients living with dementia. Staff did not admit patients to the CDU with a diagnosis of a mental health problem under a MHA section or who were agitated.
- There was an ambulatory care unit, which supported patients who did not require admission or came in for a follow-up treatment. The hospital was developing an ambulatory emergency care dashboard, so that performance could be measured against national targets. There was no data available at the time of inspection.
- Discharge arrangements for children in the ED were clear. A doctor would make a decision to discharge. Drugs would either be dispensed in the ED or a prescription would be provided for collection at a local pharmacy. A follow-up appointment was made for children at the time of discharge if required. We were told that readmission of a child to the ED was a rare event.
- Children with learning disabilities who attended the ED were dealt with through the neurological 'l'pathway' for CAMHS. There was a specialist mental health nurse who supported the children's ED. CAMHS employed a specialist nurse to offer a 9am to 5pm service for children admitted to the ED with psychiatric or emotional problems.

Learning from complaints and concerns

- Although friends and family test (FFT) questionnaires were visible, staff were not sure how the results of these were shared.
- Staff knew where the patients advice and liaison services (PALS) office was and how to access this. They were able to give examples of when they would refer patients, or their relative, to the service.

Are urgent and emergency services well-led?

Requires improvement



We rated well led as requires improvement because:

- There was no strategic plan for the future of the ED as part of the trust, once initial improvements to the services had been made.
- Records indicated that ED was represented in only three out of nine, hospital safety huddles meetings in May 2016 and only four out of 17 meetings in April 2016.
- There was a local risk register for the ED. We noted that some risks were listed on the register since 2013, including: risks to neutropenic patients not receiving treatment within the nationally agreed timeframe (one hour), inadequate staffing levels and patients being treated at the AAU for over 48 hours due to lack of beds.

However;

- There was clear nursing and medical leadership visibility with the department, and staff felt able to highlight issues to them.
- The governance arrangement were clear to staff we spoke with and from the meeting minutes we reviewed, it was clear the leadership team understood the service.
- There were numerous governance meetings in place. On a day-to-day basis, there was effective oversight of the activity undertaken by the department performed by the service manager and matron.
- The trust has identified the need for improvement and has established an Emergency Care Improvement board which is overseeing the delivery of a number of improvements.

Leadership of service

Urgent and emergency services

- Nursing staff said they were happy with the department's management. Nurses told us that their managers were visible and supportive.
- There was a lack of clarity over leadership in the paediatric department, with the nursing staff from ED and the medical staff reporting to the children's directorate.

Vision and strategy for this service

- There was no clear long term strategy for how the ED fits into the trusts strategic plan. The senior medical team was unstable, with many staff looking to move over the next 12 months. The trust told us management arrangements were being reviewed and that senior posts were being recruited for with a view to develop local strategy and improve services.
- The trust carried out a 'six-facet' survey in 2013, which included the Whipps Cross Hospital's urgent and emergency services. This survey focused on physical condition, statutory compliance, space utilisation, functional suitability, environmental management and quality audit. There was a plan to repeat the survey in 2016/17 to inform the future estate strategy and to support the site redevelopment strategy. The trust recognised that the facilities fell short of required standards required due to their age, condition and layout and that a major site redevelopment was needed.

Governance, risk management and quality measurement

- There were numerous governance meetings in place. On a day-to-day basis, there was effective oversight of the activity undertaken by the department performed by the service manager and matron.
- Performance review meetings took place monthly and were attended by a representative of the ECAM directorate (emergency care and acute medicine). Agenda items included: staffing levels, risk, management and learning from incidents and complaints, patient feedback, performance in relation to targets and key safety indicators (such as MRSA screening and infection). These meetings were chaired by the director of operations.
- In addition, there was a monthly clinical improvement group, chaired by an emergency medicine consultant.

These meetings were used for sharing learning from complaints and incidents. ED consultants, trainee doctors, nurses, the governance lead and a patient panel representative attended meetings.

- The trust reviewed the senior management structure to facilitate closer oversight and improvement within the department. There was a local service improvement team, managed by the director of operations, with an allocated improvement director for emergency care. The general manager was responsible for overseeing emergency department (adults and children), acute admission unit (AAU) and older people's services. The hospital appointed director of nursing and governance, and an associate director of nursing who was responsible for emergency and urgent care. They were supported by matrons allocated to AAU and ED. There was a clinical director for emergency and acute medicine line managed by a medical director.
- Records indicated that ED was represented in only three out of nine, hospital safety huddles meetings in May 2016 and only four out of 17 meetings in April 2016. These meetings were designed for sharing information on incidents, risks and any staffing issues with other hospital teams.
- There was a local risk register for the ED. We noted that some risks were listed on the register since 2013, including: risks to neutropenic patients not receiving treatment within the nationally agreed timeframe (one hour), inadequate staffing levels and patients being treated at the AAU for over 48 hours due to lack of beds. Risks related to lack of capacity in ED, resulting in patients being treated in the corridor, was also left unresolved for over three years on the register. Risks were graded to indicate severity; in five out of ten cases the mitigating factors did not reduce risk. There was no clearly indicated actions to reduce any of these risks recorded.

Culture within the service

- Nurses working in the children's ED told us they were proud to work there. They thought the department was well-led and they felt comfortable in escalating any issues.

Urgent and emergency services

- Nurses felt supported by the organisation. For example, when dealing with abusive patients the level of security within the ED had been reviewed to keep staff and patients safe.
- Some managers and staff told us that there had been some bullying but that this had now improved in the last six months.
- Some support staff were upset that they had been graded at a lower level than staff at other Barts trust sites undertaking the same role.

Patients engagement

- The hospital was in the process of responding to patient led assessment of the care environment (PLACE) which was published in May 2016. It included the ED department which was due to prepare their response by the end of May 2016.

- The hospital carried out patients survey which consisted questions related to patients' comfort, dignity and respect, information, kindness, understanding, involvement among other measures used.







Staff engagement

- The ED matron had a monthly meeting with all band 7 nurses and a separate meeting with band 6 nurses. There was an open meeting for band 5 nurses.
- The matron also attended staff study days to give staff an additional opportunity to voice any concerns.

Innovation, improvement and sustainability

- The ED had approved a plan and funding for two Emergency Care Practitioners who would improve flow, access and outcomes for patients.

Medical care (including older people's care)

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

Information about the service

Medical services at Whipps Cross Hospital consist of acute and general medicine, older people's services and a range of medical specialties including, cardiology, endocrinology, gastroenterology, renal and stroke services.

During 2015 there were 21,761 admissions to medical services wards.

We visited the following medical wards and units: the Acute Assessment Unit (AAU), B3, Birch, Blackthorn, Cedar, Curie, CCU, Elizabeth, Faraday, Mary, Peace, Syringa, Victory, Forest Assessment Unit, and the Renal Unit. We also visited four surgical wards where medical patients were being cared for.

We spoke with 57 staff in addition to meeting with the senior leadership team. We also spoke with 62 patients and relatives. We observed the care provided and interactions between patients and staff. We reviewed the environment and observed infection prevention and control practices. We reviewed care records and attended medical and nursing handovers, a board round and a multidisciplinary ward round. We reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

Overall we rated the service as requires improvement because:

- Infection prevention and control procedures were not strictly adhered to, increasing the risk of infection for patients. Medicines and cleaning fluids were not always stored safely and in line with national guidance.
- Staff did not take a systematic approach to individual patient risk assessments, which are required to monitor their health and well-being and reduce clinical risk. For example, assessment of risk of venous thromboembolism (VTE) and nutritional need were not undertaken consistently. In addition, care plans did not reflect the individual needs of patients with additional support needs such as a learning disability. These issues, coupled with poor availability of patients' previous medical records, reduced the safety, effectiveness, and responsiveness of care.
- Although we saw staff were considering the requirements of the Mental Capacity Act (2005) and the Deprivation of Liberty Safeguards (DoLS) for some patients, documentation of the specific decisions, treatment options and the best interest decision making process needed improvement.

Medical care (including older people's care)

- The provision of compassionate care was not consistent and patients' privacy and dignity were not always maintained. Communication with patients and their relatives, particularly relating to discharge was variable in quality and timeliness.
- A clear management structure and clinical governance framework had been put into place but needed to be further developed to realise the full benefits.

However;

- A positive culture of reporting and learning from incidents, along with the daily safety huddles and ward safety briefings, facilitated the escalation of concerns and dissemination of learning.
- Staff completion of mandatory training was good and there was access to clinical support and clinical guidelines based on best practice to enable the development and maintenance of staff knowledge and skills.
- The service was working with local commissioners and stakeholders and engaging with staff and patients to develop and improve services.

Are medical care services safe?

Requires improvement



We rated safe as requires improvement because:

- Measures to prevent and control infection were not consistently applied. In addition, the environment on the renal unit was in a very poor state of repair and there was a lack of suitable storage facilities, both of which posed a risk to the prevention and control of infection.
- We noted some improvements in the storage of medicines since our last inspection. However, some medicines were not stored in line with requirements and temperature control in treatment rooms where medicines were stored was inconsistent.
- Patient's previous medical records were not available in a timely way and a large proportion of temporary notes were in place. A systematic approach to the assessment of patients' nursing care needs and care planning was not evident.
- Assessments of risk of developing a venous thrombo-embolism (VTE) and the use of the national early warning score to aid early identification of a deteriorating condition were not consistently implemented.
- Nursing and medical vacancy levels were high in some areas, although the trust were taking steps to improve recruitment and mitigate the risk through the use of temporary staff. The level of registered nurse vacancies on AAU was particularly high. Consultants and junior doctors raised concerns about medical staffing levels at night in medical services.

However:

- The daily safety huddles and ward safety briefings which had been introduced by managers, enabled patient safety issues to be escalated and learning from incidents to be disseminated.
- Levels of completion of mandatory training were generally high although they did not always meet the 90% trust target.
- Staff were aware of safeguarding policies and procedures and gave us examples of referrals they had made.

Incidents

Medical care (including older people's care)

- One never event was reported in medical services between June 2015 and May 2016. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. The never event was related to a medicine which was administered intravenously, when it should have been administered orally. An internal investigation was completed and the subsequent review identified the root cause and contributory factors. Senior staff had developed an action plan, which was in progress at the time of our inspection.
- Staff in medical services were aware of the never event. It had been presented at a “safety huddle” to enable learning from the event to be cascaded through the hospital.
- The “safety huddle” was a daily meeting attended by a ward manager or sister from each ward. Issues with a potential impact on patient safety were discussed at the safety huddles including staffing levels, patient issues, along with serious incidents and never events. Key messages from the safety huddle were cascaded to the ward team at daily safety briefings which were held on individual wards.
- 42 serious incidents were reported for medical services between June 2015 and May 2016. Of these 34 were grade 3 or grade 4 pressure ulcers. Root cause analyses had been undertaken for these and actions identified to reduce recurrence.
- Staff were clear about how to report an incident and told us they were encouraged to report incidents when they occurred.
- An electronic incident reporting system was in place and most staff were familiar with this, although some health care support workers (HCSW) and agency nurses did not have access to the system. They told us they would report incidents to the nurse in charge of the shift.
- The Medical Director led weekly Serious Incident Risk Management and Assurance Panel (SIRMAP) meetings, which were used to discuss and resolve serious incidents.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain ‘notifiable safety incidents’ and provide reasonable support to that person. Staff demonstrated variable awareness of the duty of candour. Some staff were able to tell us about it and give examples of instances in which it had been completed, but we found some Band 5 and 6 staff did not have any knowledge of the duty.
- We saw examples of a verbal apology being given as part of the duty of candour and an example of a written apology following the never event. Managers accepted the provision of a written letter of apology still needed some work and told us there was a backlog of letters. They told us template letters were being considered to facilitate the process. There was a risk that a standardised template would not provide the personalised approach required within duty of candour.
- We saw notes of mortality and morbidity meetings held within each of the medical specialties. In some specialties, morbidity and mortality was an agenda item at general clinical governance meetings whilst other specialties held morbidity and mortality meetings separately. Documentation from these meetings suggested there was an inconsistent approach to review of morbidity and mortality. For example, notes from some specialty meetings indicated that cases were discussed in detail, but it was not clear if this approach was used in all specialties, as an overview only was provided in the notes of some which might indicate a full independent analysis of the cases was not being undertaken.

Safety thermometer

- The NHS Safety Thermometer is an improvement tool to measure patient “harms” and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harm in relation to pressure ulcers, patient falls, venous thrombo-embolism (VTE) and catheter associated urinary tract infections.
- Safety thermometer data was collected by medical services and the results were available for wards on the intranet.
- Wards did not display the safety thermometer results, however, their performance in relation to individual components of the safety thermometer such as pressure ulcers and falls were displayed on notice boards on each ward in the form of safety crosses. The safety cross is a means of recording the incidence of key factors influencing safety daily each month, giving information at a glance as to the frequency of these incidents.

Medical care (including older people's care)

- Between April and June 2016, nine medical wards reported harm free care below the national average of 94%, indicating a higher than average number of patient harms were occurring on these wards. Reducing pressure ulcers and falls had been prioritised as areas for quality improvement and actions to reduce them identified including, the provision of one to one care for patients at high risk of falls.
- Staff told us pressure ulcers and falls had reduced recently as a result of the focus on preventative actions. Data provided by the trust demonstrated that the number of falls had reduced by 50% between April and June 2016 on three medical wards (Conifer, Elizabeth, and Faraday wards) in comparison to the three previous quarters. Data provided on the incidence of pressure ulcers on the top ten medical wards indicated a reduction in May, June and July 2016 but the trend was less clear.

Cleanliness, infection control and hygiene

- Two healthcare associated MRSA bacteraemias attributable to the trust were reported in medical services between April 2015 and March 2016.
- Screening of patients for MRSA colonisation on admission to hospital in line with trust policies and protocols was not consistent and therefore increased the risk of patients with MRSA not being identified on admission. Trust data indicated that MRSA screening rates in April 2016 were 50% on Mary ward and below 90% on 11 other medical wards.
- Of the 23 cases of C. difficile (C.Diff) that occurred at the hospital between April 2015 and March 2016, 22 were attributed to medical services, although five of these occurred on the infectious diseases ward (Acacia). The number of cases reported for Whipps Cross hospital had reduced from the previous year when a total of 27 cases were reported.
- Most clinical areas were visibly clean when we visited and cleaning schedules were in place to ensure routine cleaning was completed daily. However, we found a lack of maintenance of some floors and walls, contributed to staining and the collection of dust. This was particularly evident on Elizabeth Ward (including the cardiac care unit) and the haemodialysis unit.
- On the haemodialysis unit, there were no storage areas. As a result, consumables including syringes, linen trolleys, sharps bins and acid concentrate (for haemodialysis) were stored on open trolleys at the end of the ward and in the central area between the beds. Hoists and dialysis machines were stored in the corridor outside the ward. This increased the risk of infection and presented a fire safety risk through obstruction of evacuation routes. The ward manager told us the flooring was on the risk register, but the risk register provided by the trust did not include this.
- In the Patient Led Assessments of the Care Environment (PLACE) for 2016, all medical wards audited scored over the national average of 98% for cleanliness. The overall results for Whipps Cross hospital had improved from a score of 87.59% in 2013 for cleanliness to a score of 99.17% in 2016. Elizabeth Ward and the haemodialysis unit were not assessed during these audits.
- Patients with identified infections were generally cared for in side rooms and signs on the doors warned staff of the type of infection and the precautions to be taken to control the spread of infection.
- There were no side room facilities on the Forest Assessment Unit and B3 Ward. Staff on B3 Ward told us that when patients had an infection they alerted the bed manager and tried to minimise contact with other patients by using PPE and setting up a "virtual" area. We were not able to identify how this varied from normal practice other than the contact with the bed manager to enable patients to be moved to a more suitable environment.
- The Forest Assessment Unit had initially been opened as a day unit but we were told that patients regularly stayed overnight as they were not ready for discharge and due to capacity issues in the hospital. There was no sluice on the ward and the male toilet/shower room was used as a sluice for the disposal of body fluids. If a male patient required a shower, the soiled laundry and equipment such as bedpans etc. had to be removed. This increased the risk of the spread of infection.
- On the day we visited the Forest Assessment Unit, a patient colonised with MRSA and a patient with diarrhoea and vomiting had been admitted. This meant patients with infections were in contact with other patients, increasing the risk of the spread of infection.
- We noted on Curie Ward, a patient with an infection was located in a side room next to a patient with a suppressed immune system. Signs on the doors warned staff of the precautions which were required for both patients; however, the placement of the patients did not represent best infection control practice as staff moved from one room to the other.

Medical care (including older people's care)

- We found personal protective clothing and equipment was readily available and placed strategically in all clinical areas.
- Hand sanitiser was generally readily available in most clinical areas and at the end of patient's beds. However, there was no hand sanitiser outside a side room housing a patient with an infection on Curie Ward.
- Patients told us they saw staff using the hand sanitiser or washing their hands before and after providing care. However, we observed staff were not always bare below the elbows and guidance on the use of PPE was not always followed. For example, we observed a member of staff in a side room where the person had an infection and they were not wearing an apron or gloves. When they left the side room they did not wash their hands. We also observed staff in uniform sitting on the floor in a meeting room. As a result staff uniforms would be contaminated with micro-organisms on the floor.
- Monthly hand hygiene audits completed by the trust between April 2015 and April 2016 found 100% compliance for most wards except the Forest Assessment Unit which had compliance of 70% for March and 80% April 2016 and Conifer Ward which showed compliance of 75% in March 2016. There were also some gaps in the data where audits had not been completed on some wards for some months.
- We found temporary locking mechanisms were not used on sharps boxes to keep the contents of the sharps safe. These mechanisms are provided to prevent accidental spillage of sharps and tampering with the contents.

Environment and equipment

- There was secure entry to the medical wards by keypad or call bell entry and a press button exit.
- A programme of refurbishment of several medical wards had commenced and staff told us of the plans in place to improve the environment and to incorporate "dementia friendly design" principles as part of the refurbishment.
- Several of the wards had a nightingale layout (a line of beds on each side of the ward with central staff areas) and the décor was tired and in need of attention. Maintaining privacy and confidentiality was a challenge in these areas.
- On Peace Ward (the stroke unit), the space on the ward was very limited, particularly given the requirement for mobility aids by the bedside and the rehabilitative

nature of care. The gym had new flooring and an occupational therapy kitchen was available. The trust recognised the bed spacing did not meet current national standards for health buildings and could not be easily adapted to comply given the overall constraints of the building.

- Some concentrated cleaning solutions and chemicals were stored in unlocked rooms and could be accessible to patients. This did not adhere to national guidance on the Control of Substances Hazardous to Health (COSHH).
- Store rooms on Peace Ward, Syringa Ward, and Curie Ward were disorganised and cluttered. Medical staff told us they had difficulties finding consumables on some wards. There was not always a named member of staff in place for stock control or rotation.
- Resuscitation equipment had been checked daily and equipment was stored in line with requirements.
- Portable appliance testing (PAT) had been carried out and the equipment we checked indicated it was in date.
- We noted the risk register indicated that a range of endoscopes were at the end of their life and parts would not be available if they needed repair. These had been added to the risk register during 2016 indicating the trust were aware of the issue, but the risk register did not indicate the timespan for replacement.

Medicines

- We observed medicines being administered safely. Staff checked against the medicines administration record, checked the identity of the patient and remained with the patient until they had taken their medicines. On one occasion, we observed the nurse administering medicines was interrupted frequently during medicines administration. Interruptions increase the risk of errors occurring.
- Medicines administration records had been completed consistently, allergies were recorded and there was evidence of medicines reconciliation on admission. This indicated medicines were given as prescribed and checks had been made to ensure they could be given safely.
- Patients told us they received their medicines in a timely manner and staff checked their identity prior to giving them their medicines. They also said staff explained their medicines to them. One patient said, "They have a

Medical care (including older people's care)

schedule for my tablets, I trust them.” Another patient said, “Staff explain my medicines and check who I am before I am given any medicine,” and one patient said, “They explain what I am taking, why and what it is for.”

- Rooms used to store medicines were secure keypad entry. Storage had improved from our last inspection and no expired medicines were found. However, we noted some medicines were stored in unlocked cupboards within rooms on Mary Ward, Curie Ward, and B3 Ward. We observed a note on three drawers of prescription medicines stating a lock needed to be fitted, dated 18 April 2016, but it had not been completed at the time of our inspection in July 2016.
- Temperature checks of the rooms and refrigerator where medicines were stored had been recorded daily. Refrigerator temperatures were within acceptable limits. However, the temperatures of the room used to store medicines on Curie Ward, Cedar Ward, B3 Ward and Peace Ward were above recommended temperatures on one day of our inspection. Staff had recorded similar excessive temperatures within the previous month. Ward staff had completed incident reports and liaised with pharmacists who had taken steps to reduce stock levels. However, staff were not aware of any permanent solution to the problem being planned.
- We found evidence of daily checks of controlled medicines and emergency medicines and no gaps were noted.
- Pharmacists visited each wards daily. There was no pharmacy technician to top up stock medicines on most wards and wards ordered from a stock list weekly. Nurses were also responsible for checking expiry dates. The lack of a pharmacy technician to coordinate ordering and rotation of stock could affect the safe and effective use of medicines. However, on AAU a pharmacy technician checked patient's own drugs, stocks and summary care records.
- Registered nurses were not always aware of the systems in place to obtain medicines outside pharmacy opening hours. Some staff did not know there was an emergency medicines cupboard for access out of normal working hours. However, they told us they would contact the on call pharmacist for advice.

Records

- A large number of temporary medical records were being used, some of which were patients had been

inpatients for over a week. This meant staff did not have access to notes regarding previous admissions and outpatient attendances and therefore did not always have a complete medical history for patients.

- Entries in patient's health records had been dated, timed and signed but in most cases there was no printed name of the person making the record. The designation of the person making the entry was clear in most entries. Most entries were legible but there were issues with legibility in a small proportion of the medical records. This incomplete adherence to safe standards of record keeping, increased the risk of errors occurring and made it difficult to identify the person responsible for the entries in the records.
- Initial medical assessments had been completed and there was a clear treatment plan in place for each person, which had been reviewed and updated.
- Nursing records did not contain a comprehensive assessment of patients' needs and risk factors. We found staff had completed some individual risk assessments but these were inconsistent. For example, a pressure ulcer risk assessment and falls risk assessment had been completed for most patients and a nutrition and moving and handling assessment had been completed for some patients, but this was not consistent. When bed rails were in use to prevent a patient from falling out of bed, risk assessments had been completed to ensure they could be used safely.
- Standardised nursing care plans (referred to as “nursing care standards”) were in place for some aspects of nursing care and care was evaluated in relation to these. However, they had not been personalised for the individual patient and were not in place for all aspects of nursing care. For example, there was no indication of the support people required with their personal hygiene, elimination (except when they had a urinary catheter in place), cognition, emotional needs or communication.
- When patients were at high risk of developing pressure ulcers staff used a care bundle (SSKIN) which had been completed consistently indicating a systematic approach to pressure ulcer prevention. Records of regular checks of patient well-being and other required interventions were consistently documented.

Safeguarding

Medical care (including older people's care)

- The trust had an adult safeguarding policy which had been reviewed in 2015. This included a procedure in the form of a flow chart to guide staff through the process.
- Adult safeguarding training was included in the trust's mandatory training programme with a trust target of 90% completion. At least 90% of nursing staff had completed level 1, safeguarding adult training on all medical wards/units. Over 90% of staff had completed level 2 training on seven of the wards/units, whilst all of the remainder had compliance of over 80% except for B3 Ward (63%), Birch Ward (69%) and Blackthorn Ward (70%). Over 90% of medical staff had completed training. Over 90% of consultant medical staff had completed level 1 training but completion of level 2 training was only 53% for consultants in respiratory medicine, 60% for gastroenterology, 62% for diabetes and endocrinology and 66% for rheumatology.
- Staff were able to describe the signs of abuse and were aware of the procedure for reporting safeguarding concerns. They were aware of the trust safeguarding lead and told us they could contact them for advice. They told us that they had good links with social services and were able to discuss concerns and obtain advice where necessary.

Mandatory training

- Mandatory training covered 23 different topics including privacy and dignity, nutritional care, moving and handling, infection control, fraud awareness, dementia awareness, health and safety and a wide range of other topics.
- Data supplied by the trust indicated that completion of mandatory training was high. The trust's target was for 90% of staff to have completed each mandatory training topic and whilst this was not achieved for all topics for all areas of medical services, most had achieved at least 80% completion. The exception being medical gas safety, where compliance levels of approximately 50% were achieved.
- When looking at compliance with mandatory training by professional group, medical staff in medical services achieved 81% compliance overall. Compliance with mandatory training overall amongst nursing staff was 83%.

Assessing and responding to patient risk

- An early warning score (NEWS) was used to ensure the prompt identification of patients when their condition

deteriorated. Standard triggers of escalation were clear and there was the ability to adjust the trigger for individual patients to allow for differences in patients' normal readings. We observed that the parameters for triggering escalation were set for individual patients on Elizabeth Ward (Cardiology) and these were agreed at ward rounds. A score was recorded with each set of vital signs observations.

- When a patient's condition required escalation, staff contacted the junior doctor for the ward or out of hours they could contact the hospital at night, nurse practitioner. Staff told us the doctors responded promptly to escalation whenever possible, and if they did not obtain a prompt response they would escalate to the registrar or consultant.
- An acute response team had been introduced, but there was a lack of clarity about the role of the team and their involvement in the escalation process when patients deteriorated. Staff told us the team supported patients who were stepping down from the intensive care unit and those requiring CPAP (a form of ventilation) who could not be admitted to the intensive care unit.
- The trust had completed monthly audits on the use of the early warning score on medical wards. These indicated an average compliance of 80% in March 2016. Compliance levels ranged from 75% on Conifer Ward and Curie Ward at the lowest, to 93% on Elizabeth Ward.
- The assessment of patients for risk of venous thrombo-embolism (VTE) was recorded on the medicines administration record. We observed that the assessment had been completed on admission for most patients and where necessary the required medicines had been prescribed, although we found this was inconsistent on Syringa Ward and Cedar Ward.
- The trust's audits of VTE assessment, indicated variability in the use of the score. For example, Faraday Ward, Cedar Ward, Chestnut Ward showed only 50% compliance in March 2016 and Syringa Ward, Blackthorn Ward, Birch Ward, Victory Ward, Peace Ward and Acacia Ward scored 100%.

Nursing staffing

- The trust used a recognised tool (Shelford) to determine its nurse staffing levels. Reviews of nurse staffing levels and skill mix had been undertaken for the medical wards within the previous twelve months except for AAU. Staffing levels had been increased following the review.

Medical care (including older people's care)

- Wards with low levels of vacancies, reported adequate staffing levels and told us of the positive impact of the review. For example, the Syringa ward had had their staffing levels increased to allow an additional healthcare assistant to be on duty during the day and they were able to obtain one to one support when a patient required it. They told us this had reduced the number of patient falls on the ward.
- Staffing levels on Peace Ward (the stroke unit) were in line with the London stroke standard.
- However, vacancy levels were high on some medical wards and there was a high use of agency staff. For example, there were 8 Band 5 registered nurse vacancies on Curie Ward and B3 Ward. There was an overall total of 15 nurse and healthcare assistant vacancies on Mary Ward and the ward manager and some of the staff were newly appointed. Staff told us they were able to request agency staff to enable them to achieve their agreed staffing levels and in most cases they were able to achieve their agreed numbers. Whilst staff appreciated the ability to obtain temporary staff to cover the gaps in the roster, on some wards they felt the proportion of temporary staff to permanent staff impacted on their ability to improve the safety and quality of care.
- Patients and their relatives on Mary Ward said they felt the ward was understaffed. One person said, "It seems they [staff] have a lot to do and they are always under pressure. I can't blame them for being understaffed." "Although I think they are doing their best, if I press my buzzer it will take them about 15 minutes, because they are so busy."
- The ward manager on Curie Ward told us they had obtained agreement to guarantee hours for agency nurses to enable them to use the staff who were familiar with the ward and therefore maintain the safety and continuity of care. This had occurred on some other medical wards when vacancy levels were high.
- AAU was particularly affected by the high level of Band 5 nurse vacancies. Out of an establishment of 49.82WTE there were only 9WTE in post and we were told a further four Band 5 nurses were due to leave. In order to mitigate the impact and retain staff, four additional Band 6 staff had been appointed above the agreed establishment. As a result, permanent Band 5 and 6 staff could be rostered to the high acuity areas with support from temporary staff, but temporary staff were rostered to lower dependency areas with only the oversight of the ward manager/ shift coordinator.
- Contributory factors in the never event which occurred on the AAU were identified as the staffing establishment at night and high acuity and short staffing on the night of the incident. The unit had two fewer registered nurses than their planned levels when the incident occurred.
- The reduced ability to support and monitor temporary staff due to the very high numbers being utilised was apparent during our inspection.
- 10 new staff had been recruited and a practice development nurse was in post to provide support to new staff. As a result of concerns about AAU staffing levels, a staffing and skill mix review was being undertaken.
- The trust was taking steps to recruit new staff and there were a number of recruitment initiatives taking place at the time of the inspection. When we discussed the vacancy levels with ward managers, we were told that although the current vacancy level was high, the majority of the posts had been recruited to and they were waiting for new staff to start and where this was not the case, they were hopeful that the current overseas recruitment initiative would be successful in recruiting the staff they required.

Medical staffing

- A medical consultant or geriatrician was available on all medical wards between 9am and 5pm Monday to Friday. Consultants led daily ward rounds on medical wards and either a daily consultant ward round or board round took place on the geriatric wards. A consultant was available on the AAU between 7am to 3pm. Outside of these hours the on-call consultant was available initially on site in the evening and later on call. There was a consultant on the ambulatory care unit until 5pm.
- At weekends a medical consultant performed a post take round from 7am to 10am and evening post take round from 4pm to 9pm. For older people's services, a geriatrician performed a morning post take round from 9am to 11am and an evening post take round from 3pm to 6pm. Outside these hours there was a medical consultant and a consultant for older people's services on call. A gastroenterologist was on call 24 hours.

Medical care (including older people's care)

- The medical staffing skill mix was lower than the national average for the percentage of consultant and middle career doctors and there was a larger than average proportion of specialist registrars.
- The trust reported 36 medical staff vacancies in acute medicine. This was mitigated by the employment of long term locums and increased frequency of on call duties. High consultant vacancy levels in older people's services were identified as a risk on the risk register. However, the trust had been successful in appointing four new consultants who were due to start work in the coming months. As some of the vacancies were due to an increased number of consultant posts, the rota was unaffected.
- Medical staff told us there were gaps in the junior doctor rota and medical cover at night was variable. One member of staff said, "There are good and bad weeks." We checked a medical rota for March 2016 and this showed some gaps in the rota. We were told attempts were made to cover vacancies with temporary staff, but that skill mix issues compounded the problem due to uneven rostering of permanent staff. As a result the number of junior medical staff and their experience was variable.
- Consultants and junior doctors felt that even when the planned staffing levels were achieved there were not enough junior doctors to cover the high number of inpatients at night. They said the impact was that they had to prioritise sick patients and little routine work was completed. One member of staff said, "Although it is stressful, there is no real evidence of danger to patients, but it feels dangerous because you are rushing." Another member of staff said staffing levels impacted on their ability to discharge patients in a timely manner.

Major incident awareness and training

- A major incident plan was in place dated April 2015.
- Emergency planning training was part of mandatory training. At least 70% of staff in each area of medical services had completed emergency planning training except on Faraday Ward where approximately 50% of staff had completed training.
- Ward sisters and ward managers were aware of their role in a major incident and the action they needed to take.
- We noted there was emergency evacuation equipment near the fire exits and on B3 ward we noted there was an evacuation/fire plan on the wall.

Are medical care services effective?

Requires improvement



We rated effective as requires improvement because:

- Assessment of patient's nutritional status on admission was not consistently completed and therefore patients at risk of malnutrition were not always identified.
- Results from national audits showed the trust performance to be below the England average in many of the measures in the national heart failure audit, the Myocardial Infarction National Audit Programme (MINAP) and the National Diabetes Audit (NDiA).
- Further development of seven day services was required to provide a consultant review of all patients seven days a week, provision of therapy services at weekends and access to diagnostic and interventional imaging.
- Although we saw some evidence of mental capacity assessments when people could not make specific decisions for themselves, these were not always completed and the best interest decision making process was not documented.

However:

- Staff had access to clinical protocols and guidelines on the trust intranet and a programme of audits was in place for 2016 to measure adherence to best practice guidance.
- The trust participated in national clinical audits and outcomes were measured. There was some evidence of action being taken to improve performance and outcomes for patients.
- Patients' pain was assessed and managed well.

Evidence-based care and treatment

- Staff were aware of National Institute for Health and Care Excellence (NICE) guidance relevant to their specialty and they told us they adhered to the guidance.
- We were given examples of adherence to NICE guidance (NG33) for tuberculosis (TB) which covered the screening, diagnosis and management of patients with TB.
- A programme of audits was in place for 2016 to examine adherence to a range of NICE guidelines including managing anaemia in chronic kidney disease and management of diabetic foot problems.

Medical care (including older people's care)

- Care pathways were in place in some services, most notably cardiology and ambulatory care. Medical staff in ambulatory care told us they could not always follow the care pathways, as they were unable to obtain investigations such as MRIs and echocardiograms in the timeframes stated. However, other aspects of the care pathways were followed.
- Nursing staff knowledge of the evidence base of their practice was variable. When we asked two ward managers about the care standards used in the nursing records, they told us they had been developed by senior managers and they did not know of the background evidence or if they followed national guidelines. However, nurses working in specialist wards such as Peace Ward and Elizabeth Ward were aware of national guidance in relation to their specialty.
- The nationally recognised SSKIN bundle was in use to ensure a consistent approach to prevent the development of pressure ulcers and the national early warning score (NEWS) was used to identify deteriorating patients.
- Local policies and guidelines were in place and the sample we reviewed were in date and linked to national best practice guidance.

Pain relief

- Pain scores were used to assess patients' pain levels and were documented consistently.
- Patients' experiencing pain had generic pain management standards in place in their care records. We saw an example of a patient who had had their pain control reviewed and their medicines changed to reduce their pain levels.
- Patients we talked with said that staff regularly checked whether they had pain and provided pain relieving medicines when they needed it. One patient said, "Last night I had pain in my shoulder; I put my hand up and the nurse comes straightaway, looks at me, and gives me two tablets to ease the pain and I fell asleep, so I was happy about that really."

Nutrition and hydration

- The trust had identified from the results of their audits, that assessment of patients for risk of malnutrition required improvement. Ward completion of the nutrition risk score for patients was displayed along with other on the quality indicators on ward notice boards

and we found scores of 56% displayed on Mary Ward and 70% on Syringa Ward. However, it was not one of the key performance indicators on the ward performance dashboard.

- We observed a lack of a consistent approach to assessing patients' nutritional risk during our inspection. We found nutritional risk assessments had not been undertaken for all patients on admission. This meant that patients at risk of malnutrition might not be identified on admission.
- Records of patients' food and fluid intake were not consistently maintained and when the patient was not receiving intravenous fluids, we found daily totals of patients' fluid intake were not always calculated making it difficult to assess patient's food and fluid intake. It was therefore possible patients with inadequate intake would not be identified.
- Patients' opinion of the quality of the meals was very variable. Of the 22 patients we talked with about their perception of the food, 12 told us it was good or adequate, whilst 10 patients told us it was poor. Comments ranged from, "Excellent food I can say, not something I expected, but it's excellent," to, "I prefer not to eat here as the food is really bad." There were several comments about the meals being cold when they were served.
- All the patients we talked with said they were provided with fresh water at their bedside and they had access to hot drinks regularly.
- We observed the lunchtime meal on two wards. On Syringa Ward we observed that when the meals trolley arrived, staff were mobilised by the nurse in charge and were engaged in giving out the meals. Hand wipes had been placed on the trays to enable patients to clean their hands prior to the meal. Some patients requiring assistance were provided with assistance promptly, but the meal for some others was left on the side (unheated) for 10 minutes before they were assisted. The number of patients requiring assistance was such that even if all staff were involved in assisting patients, they could not all be assisted at the same time.
- On another ward, the heated trolley was not connected to a power supply initially and when staff were asked, by a senior nurse, to move it to where it could be plugged in, their reaction indicated it was not normally plugged in. This may explain the comments by patients on some wards that their meals were cold when they were served.

Medical care (including older people's care)

Patient outcomes

- The trust had the largest cohort of patients with TB in the north east London sector and data was entered onto the London TB register allowing comparison with other centres. Mortality rates were low and the lead consultant told us treatment outcomes compared favourably with other providers.
- The trust participated in national audits relevant to the service.
- In the Sentinel Stroke national Audit (SSNAP) between October and December 2015, the hospital scored "B" overall, in a range of "A" to "E" with "A" being the best and "E" being the worst. This was an improvement on the score of "D" achieved between July and September 2015. Although information initially supplied by the trust indicated there was no action plan for this audit, the management team told us there was a clear action plan address the areas for improvement identified in the audit. However, despite a second request, this was not supplied.
- Whipps Cross Hospital performed worse than the England average for 10 of the 17 measures in the National Diabetes Inpatient Audit (NDiA) and better than the England average in six measures. There was an action plan to address the areas arising from the audit, and the management team and a consultant told us of the development of a diabetic foot care pathway, which they had led and which was being implemented across the whole of the Barts trust. The action plan indicated there were plans for a NICE compliant diabetic foot ward round and a joint-diabetes podiatry clinic which were awaiting approval from commissioners.
- In the Heart Failure Audit (2014), the site scored worse than the England average for three out of four of the in-hospital indicators and five of the seven discharge indicators. However, the number of patients included in the audit was very small which meant the results may not be comparable with other trusts.
- The hospital also scored worse than the England average in the Myocardial Infarction National Audit Programme (MINAP) in 2014. Following this, the trust had appointed a nurse to improve data collection for the audit.
- Cardiology services at Whipps Cross was a networked service with Barts Hospital and the clinical director for cardiology was based on the Barts site. There was a clinical lead at Whipps Cross and the patient pathway

was being reviewed. A key issue in relation to the results of both the heart failure audit and the MINAP audit was the cardiac care unit (CCU) capacity and an inability to accommodate female patients on the cardiology ward. Patients were therefore frequently cared for on general medical wards meaning the criteria in the audits for the specialised care of patients was not met.

- Endoscopy had achieved Joint Advisory Group (JAG) accreditation. JAG sets national standards for gastro-intestinal endoscopy and accreditation provides assurance that a service is meeting the required standards.
- The average length of stay of patients in medical services at Whipps Cross hospital was slightly higher than the national average and there was a much longer length of stay for pain management (17.6 days as compared to 2.6 days). However, the number of patients who were admitted as inpatients for pain management was very low, with most patients being managed as day cases.
- The relative risk of re-admission for the service was similar to the England average for elective admissions and higher than the national average for non-elective admissions.

Competent staff

- Junior doctors told us they had named educational and clinical supervisors and had teaching ward rounds. They had access to weekly teaching sessions. Foundation year one doctors had two hours formal training on a weekly basis.
- A specialist registrar told us it was difficult to get the training they needed for their portfolio but, "people are listening." Additional clinics had been identified for them to attend to enable them to complete their portfolio.
- Junior doctors also said they felt part of the team and well supported. They said they could always contact more senior doctors and consultants for advice if required.
- We talked with two nurses on a return to practice course, a newly recruited nurse from overseas and a student nurse. They had had a formal induction and felt they had good support. They met with their mentor/preceptor regularly
- Nursing staff told us they had access to in-house courses but it was more difficult to access external courses due to reductions in funding recently. For example, a key

Medical care (including older people's care)

factor in the retention of staff in cardiology was the ability to fund them to undertake a university accredited cardiac course and there had been difficulties with funding.

- Staff told us they had had an appraisal last year and the appraisals for 2016 were now due. Most ward managers had a schedule of appraisals for the year. Appraisal rates ranged from 57% in respiratory medicine to 79% in older peoples and stroke services. A locum consultant told us they were appraised by their agency rather than having an appraisal within the trust.
- Some of the ward managers had not undertaken any leadership or management training but this had been identified by senior nurses and there were plans to address this.
- Patients were generally very positive about the skills and knowledge of permanent nursing staff but were less confident in the skills of temporary staff. For example, one patient said, "I would say the permanent staff here on Faraday Ward are fantastic, but the problem lies when agency staff are working; I don't think they know what they are doing. . . , to the point when I have corrected them about my medication."
- Temporary staff were given a brief orientation and induction to the area they were working in using a checklist. The agencies supplying the temporary nursing staff were asked to confirm whether or not they were competent to administer intravenous drugs prior to them undertaking this task.

Multidisciplinary working

- We observed effective multi-disciplinary relationships and cooperation between different professional groups. Staff told us that multi-disciplinary team working was good. Therapists felt part of the teams in the specialties they worked in. One member of staff said medical staff and nurses were working better together as there was better communication through board rounds and ward rounds.
- There was evidence within the care records of multi-disciplinary input into the care of patients including physiotherapists, occupational therapists, and dieticians.
- We were given examples of effective formal multi-disciplinary team (MDT) meetings such as the

weekly lung cancer MDT which was attended by the pathologist, oncologist, chest physician, cardiothoracic surgeon, lung cancer nurses, and registrars on a regular basis and which other teams attended as appropriate.

- A psychiatric liaison team employed by the North East London Foundation Trust (NELFT) were based in the hospital and worked closely with the multi-disciplinary teams and attended MDT meetings. There were good working relationships with the dementia team.

Seven-day services

- The trust told us that seven day services were 'in development.'
- At weekends, consultants saw new patients and there was a discharge team at weekends, otherwise consultants provided on call cover.
- There was no access to interventional radiography at weekends on the Whipps Cross site and patients requiring urgent interventional radiography were transferred to Barts Hospital.
- Occupational therapy was a weekday service and physiotherapy was staffed to provide acute respiratory, post-operative and discharge work at weekends.
- Pharmacy was available seven days a week with a reduced service between 5pm and 9pm and at weekends.

Access to information

- Policies and guidelines were accessible to staff via the trust intranet. We found they were easy to access and the guidelines we checked were current. However, a locum consultant could not gain access to the guidelines through the trust intranet but told us they were familiar with them.
- Staff reported that the IT system was slow, it was unreliable and there were not enough computers. We were told that smart cards did not always work and on some days, particularly at the end of the day, there were access problems.
- A computerised record system was in use in cardiology which functioned as networked service and staff were therefore reliant on the system functioning effectively. There was a backup computer on the ward but we were told that there had been a power failure the previous weekend which had prevented access for a full day.
- Care summaries were provided for patients to take to their general practitioner on discharge from hospital to ensure continuity of care in the community.

Medical care (including older people's care)

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us staff asked for their consent prior to any care and treatment. One patient said, "They [staff] always ask permission, and ask me whether I am happy to carry out procedures."
- Some records contained a form entitled, "Capacity, consent to admission and care." We saw an example where the form had been completed by staff stating the person had consented.
- In other cases, the form had been used to record a capacity assessment when the person did not have capacity to make decisions themselves. It was not decision specific however, it illustrated that the person's capacity to consent had been considered. Staff had then documented that a Deprivation of Liberty Safeguards (DoLS) application was to be completed online.
- We could not review the DoLS applications, but we did not see any documentation of best interest decisions in relation to specific aspects of patients' care and treatment in their care records. As a DoLS authorisation is not required for all decisions for which consent is needed, we would have expected to see a record of a mental capacity assessment and a best interest decision in relation to specific decisions.
- We also found that some patients, who were not able to consent to aspects of their care and treatment, did not have any record of mental capacity assessments or best interest decisions.
- When DoLS applications had been authorised, the authorisation letter was present in the person's care record.
- Information about the Mental Capacity Act (2005) and DoLS was displayed on noticeboards within the ward areas.
- Staff had a basic understanding of capacity and consent and told us when people could not make decisions about their care and treatment, a DoLS application would be made. A senior doctor told us they completed mental capacity assessments regularly, but when asked how it was documented, they could not explain and said the occupational therapist had a form.

Are medical care services caring?

Requires improvement



We rated caring as requires improvement for because:

- Although we observed a positive and caring attitude from many staff, we also saw examples of poor interactions and a lack of empathy for patients and their relatives.
- We received mixed feedback from patients as to the care and compassion shown by staff.
- People's dignity was not always preserved when people were assisted by staff and the extensive use of open backed gowns impacted on this.
- Some patients felt there was little emotional support available for them.

However:

- Most patients told us they had received good explanations about their care and they felt involved in their care.

Compassionate care

- The percentage of patients recommending the ward in the national Friends and Family Test (FFT) in April 2016 ranged from 60% on Chestnut Ward to 98% on Elizabeth Ward. However, there was month on month variability in the scores and in March 2016, Chestnut Ward scored 100% and Mary Ward had the lowest percentage of patients recommending the ward at 79%.
- We were given some positive feedback on the attitude of staff and their approach to care. For example, a patient said, "If you have a problem, they are very sympathetic towards you, that and caring. The way they treat me is very good." Another patient said, "Nurses go beyond the call of duty." A relative told us, "My (relative) tells me the staff are very caring and on the ball. She can ask the nurses anything and they will do everything to help her."
- We also observed some very positive and caring interactions between staff and patients. For example, we observed a health care support worker, holding a patient's hand and listening to them, showing empathy

Medical care (including older people's care)

and understanding. On another occasion when a patient presented with behaviours others may find challenging when being assisted to move, the nurse gave reassurance and asked whether they had pain.

- However, we were also given some less positive comments about staff attitude and approach. For example a patient said, "They tend to be patronising and condescending; speak to you as if you are a child." "The general assumption is that everyone is the same, when they obviously aren't." Another patient said, "They're not really rude, but assertive the way they talk to you and usually the doctors talk over you." "Sometimes staff just ignore you and walk down the corridor."
- We also received feedback from other patients that staff talked over them. For example, "They [nurses] talk over your head, but I think they do their best," and "Doctors talk at you not to you."
- We received a specific comment about staff at night being unkind on Mary Ward and reported this to the ward manager. This was immediately escalated to senior managers and action taken to investigate the issue.
- Patients commented on the high use of agency staff particularly at night and felt some agency staff did not have a caring attitude. One patient said, "I have noticed that agency nurses are less caring and less bothered, sometimes ignoring patients." Another said, "I never ring the bell as staff don't seem responsive. I've seen night staff asleep in chairs."
- A patient with a learning disability told us "Some nurses have a bad attitude." They told us of an occasion when an agency nurse had been angry when they had been incontinent. However, the patient did not provide any specific information about the details of this and when it had happened.
- We observed some rough handling of a patient who needed help to re-position. We reported this to the nurse in charge, who informed senior managers and immediate action was taken.
- We carried out structured observations on two wards during the inspection visit. We found little or no interaction between staff and the patients we observed, despite staff approaching a patient and removing their oxygen mask.

- Patients told us and we observed, staff respecting patient's privacy when providing care by drawing blinds and curtains. One patient said, "They respect my privacy as they close the curtains and explain what they are going to do."
- However, there was extensive use of open backed hospital gowns; a member of staff on one ward said that patients did not often bring their own clothes to wear. Use of this type of gown made it difficult to preserve patients' modesty and ensure they were covered appropriately. For example, we observed a patient being assisted to the bathroom on a commode with their back and bottom fully exposed as they moved across the ward during visiting. We also saw patients with the gowns falling off their shoulders and exposing them to differing degrees.
- We also observed a doctor speaking to a visitor about their relative who was deteriorating. This was done in the middle of the ward, offering the relative no privacy. The interaction between a nurse who was also present, and the relative, was limited and the nurse was quite abrupt in her manner.

Understanding and involvement of patients and those close to them

- Most patients told us staff explained their care and treatment to them and they felt involved. One patient said, "You don't have to ask anything about your care; the doctor and nurse just come and explains procedures and makes sure I understand." Another patient said, "Every day I see my doctor and talk to him about my condition," whilst another said, "I am very involved in my treatment."
- However, whilst some patients knew about the plans for their imminent discharge and were clear about the plan, others felt they had not been given enough information. A patient said they were due to be discharged the following day but had not been given any information about their aftercare. Another patient told us they were due to be discharged and had not been asked how they would cope at home.
- We saw a range of information leaflets were available for patients on different conditions relevant to the ward specialty to enable them to better understand their condition. For example, information about stroke was available in a range of different languages on Peace Ward.

Medical care (including older people's care)

Emotional support

- Some patients told us they received emotional support from the staff caring for them; however others said there was no emotional support as staff were too busy.
- A patient who had had a diagnosis of cancer said, "They [staff] couldn't do enough." They went on to say they had had support from doctors and the specialist nurse.
- We noted there was information available on pastoral and spiritual care on the wards.

Are medical care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Although work had been started to improve patient access and flow through the service, further improvements were needed to ensure the most effective use of the services available.
- Care planning and provision did not always take account of people's individual needs and preferences, particularly in relation to the most vulnerable patients.
- Although a programme of work had been agreed to improve the ward environment for people with dementia, the environment had not been adapted at the time of the inspection visit.

However:

- Services had been planned and developed to meet the needs of the local population and there was joint working with commissioners and other local stakeholders.
- Staff were aware of the themes from complaints and action was being taken to address these.

Service planning and delivery to meet the needs of local people

- The service worked with stakeholders and commissioners to develop services to meet the needs of the local population.
- There was a high rate of diabetes in the local area and in response to this, a diabetes steering board was put into place with representatives from the trust, commissioners and the community, including patients. The ideal service was described and a one year pilot

introduced to improve diabetes prevention and management in the local community. This included education for people with diabetes and GP education and advice.

- A similar model was being considered for chronic obstructive airways disease.
- A monthly insulin pump and young persons' diabetes clinic with the diabetes specialist nurse was scheduled for late afternoon, to ensure the cohort of predominantly university students and working people could be reviewed with minimal interruption to their studies or work.
- The number of people with TB in the local area was high although numbers had dropped recently due to better management due to better management and changes in the demographics. In response to the high numbers, a clinical nurse specialist and outreach worker had been appointed for TB. Meetings were held with the local GPs two or three times a year and information and training provided. The TB service was provided on a number of sites and the patient was able to be seen at the clinic closest to where they lived.
- The cardiology service was working with the clinical commissioning group (CCG) to locate additional clinic space to enable clinics to be held close to patients' homes. A pilot study was being undertaken in collaboration with the CCG in which patients were seen within two weeks of referral and followed up in the community. Heart failure nurses provided outreach into the community.

Access and flow

- A number of initiatives had been introduced to improve access and flow within the service. This included a frail elderly assessment unit and ambulatory care unit to avoid the need for patients to be admitted where possible, and initiatives to accelerate discharge, including a discharge lounge, working with community partners to develop early supported discharge and a team of patient flow coordinators.
- Patients were admitted to AAU from A&E or following referral from GPs. The aim was for patients to stay in AAU for a maximum of 48 hours before being transferred to a ward or being discharged home. However, some patients stayed for longer periods if there were capacity issues on the wards. During the inspection we noted

Medical care (including older people's care)

there were empty beds at the start of the day, which meant patients could be moved from A&E in a timely manner. Staff told us the position in the morning was variable and they could start the day with no empty beds.

- Board rounds and wards rounds were conducted throughout the day on AAU to review patients and make decisions as to their expected date of discharge and/or the ward they were to be admitted to. We observed a board round and a ward round and found there was good attendance and an effective exchange of information.
- The ambulatory care unit was designed to provide an urgent non-emergency pathway for older people, allowing investigations, diagnosis and treatment to be completed and the patient to return home. The service accepted referrals from GPs, A&E and other community providers. Data collected by the service during the pilot study in 2015 showed a reduction in patient admissions.
- The ambulatory care unit was staffed by locum consultants and junior doctors. There was one patient examination and assessment room, and up to four beds in the triage area of AAU were used when patients needed to stay for a short period, or if they needed admission.
- Patients from A&E requiring follow up could be asked to attend the ambulatory care unit. There was no appointment system and patients were asked to attend after 9am. Although we were told of the positive impact of the ambulatory care unit in improving flow and reducing admissions, we also told of inappropriate referrals to the unit and although an operating policy was in place, there was a lack of clarity about this amongst staff.
- The Forest Assessment Unit had been opened to provide assessment of frail elderly patients and used a multi-disciplinary approach to the assessment of people's needs in the community. It had been opened as a day unit initially, however, frequently remained open overnight. The criteria for admission to the unit had been reviewed to reduce the number of patients being referred who required a longer stay and an admission to hospital. We were told patients had been referred to the unit with broken hips, cerebral bleeds and pressure ulcers. This was not the appropriate pathway for those requiring emergency interventions and an inpatient admission.
- When we visited the Forest Assessment Unit we observed two patients with possible infections were admitted to the unit. There were no side room facilities to enable these patients to be separated from others in the unit.
- Meetings led by a senior manager were held three times daily to review bed occupancy, staffing levels and patients who were nursed in wards not specific to their specialty.
- Patient flow coordinators worked closely with the integrated discharge team and complex discharge team to expedite tests and investigations patients required prior to the decision to discharge being made. They liaised with external care providers and internal departments to smooth the patient journey and improve discharge.
- Staff felt the interface between the acute hospital and community rehabilitation units was challenging as they worked across four boroughs and there were delays in the ongoing transfer of care. They felt the integrated discharge team was having a positive impact, but they told us it was taking time to bring teams together.
- On AAU a junior doctor was allocated to focus on patient discharge and ensuring all patients' medicines to take home were prescribed in a timely fashion. This, coupled with a high level of pharmacy input and the use of some pre-packed medicines for patients to take home, reduced discharge delays due to medicines issues.
- We found a lack of documented discharge planning in care records. For example, the records of a patient who was partially sighted and lived in sheltered housing with some support, stated "Aim: Home later today/tomorrow," but the discharge checklist had not been initiated. On another ward there was no discharge plan for a patient going home the following day.
- A recurring theme from complaints in medical services was around communication about discharge and the patients' and relatives discharge experience. Senior managers told us they were developing an information pack for patients and relatives to be provided on admission to provide information on what to expect in relation to discharge. They also recognised the need to pre-empt discharge and provide more information for families when a patient was likely to be discharged within the next 24 to 48 hours.
- Cardiology was a networked service with Barts Hospital. There was a coronary care unit (CCU) on Elizabeth Ward and male step down beds. Due to the layout of the

Medical care (including older people's care)

ward, and the inability to separate patients by gender, female cardiology patients who did not require CCU were cared for on general medical wards. Diagnostic angiography was carried out at Whipps Cross Hospital, but patients were referred to Barts Hospital for any treatment such as angioplasty.

- When a patient was admitted to AAU, cardiology doctors would see the patient, but patients admitted to general medical wards were not seen by a cardiologist until they were referred by the medical team caring for them. Patients requiring angiography at Barts Hospital were not normally referred until they were admitted to Elizabeth Ward, as they would need to come back to Elizabeth Ward after the angioplasty. This added a delay into the patient pathway. We were told a pathway was being developed to enable patients to go to Barts Hospital for angiography direct from AAU and then return, or be discharged whilst they were at Barts Hospital.
- Bed occupancy at Whipps Cross Hospital was over 96% between January 2016 and April 2016. The trust reported 66 medical patients were not placed in the appropriate ward due to capacity issues in medical services in April 2016 and similar numbers were reported in the three months previously.
- We visited four surgical wards to review the arrangements for medical patients being cared for on surgical wards due to capacity issues on the medical wards. Patients were allocated to a medical consultant and the medical team visited the wards daily to review their patients.
- A significant number of patients were moved between wards after 10pm. Trust data indicated that in April 2016 there were 299 moves at night on medical wards excluding AAU.

Meeting people's individual needs

- A dementia and delirium team were available on site to provide clinical advice and support for patients living with dementia and delirium and their carers. Most medical wards had an identified delirium champion.
- Audits completed by the trust indicated that 90% of patients aged 75 years and over were screened for dementia and delirium on admission to hospital against a target of 85%.
- At the time of the inspection, limited work had been completed to make the environment more suitable for

people living with dementia, however funding had been obtained and a programme of refurbishment had commenced primarily focussing on the care of the elderly wards.

- Activities boxes were being introduced onto wards to provide a range of activities particularly suitable for people living with dementia.
- The "Forget me not" template was used to record important information about the person with dementia and we found these had been completed for some people living with dementia but this was not consistent.
- Although the trust had a flagging system to identify people with a learning disability, staff awareness of adjustments which could be put into place for patients with a learning disability was limited.
- A patient with a learning disability told us they did not feel safe on as ward as some staff were unaware of the needs of people with a learning disability. They said their relative stayed with them throughout the day as they did not have confidence that consistently good care would be provided. They told us they had been to the hospital on many occasions.
- Care plans did not contain any personalised information about the patients and purely gave generic information on the management of specific nursing interventions.
- Translation and interpreting services were available for patients whose first language was not English and for patients who were hearing impaired. Staff were aware of the availability of the services and how to obtain an interpreter if needed. We saw information about interpreting services was available within the AAU.
- The trust had not declared any breaches of the requirements for same sex accommodation in medical services in the previous year. However, both male and female patients were accommodated on the coronary care unit section of Elizabeth Ward which did not have the capacity to segregate them according to gender. The other half of Elizabeth Ward accommodated male cardiology patients and these patients passed through the coronary care unit to access toilet and shower facilities.

Learning from complaints and concerns

- Notice boards within the ward areas provided information about the patient advice and liaison service (PALS) and complaints. These boards also provided information about improvements which had been put into place in response to complaints and feedback.

Medical care (including older people's care)

- Most patients told us they would not know how to make a complaint and did not know who the ward manager was.
- A patient who told us they had made a complaint about their medicines said, "I don't think the manager and the nurses took it seriously because I didn't even fill in a form."
- 65 complaints had been received in relation to medical services between May 2015 and April 2016. A theme from complaints in medical services was communication about discharge and discharge arrangements. Staff were aware of this and told us of a number of actions taken to improve but accepted that additional improvement was needed.
- Complaints were discussed at the morning ward safety briefings and at handover.
- From September 2016, a site based leadership team had been introduced and senior nurse leadership in medical services had been strengthened to provide more on site presence following the last inspection.
- Staff told us they saw the management team more frequently and that leadership was more visible. They said the escalation process was clear and much easier than previously.
- Some of the management team had been very recently appointed and therefore the impact on the service had been limited at the time of the inspection.
- We observed variability in ward leadership with some strong ward managers with expertise, enthusiasm and experience, and other inexperienced ward managers who needed support and guidance. In addition, when we visited one ward, the ward manager was in their office with the door locked. We were told prior to the visit, that they spent most of the time in their office. A senior nurse told us leadership courses were planned to address the gaps in experience and approach.
- Some wards had staff meetings every one to two months whilst others did not hold regular staff meetings.
- Ward managers told us ward manager meetings were held which provided peer support and the opportunity to discuss common issues and share learning.
- Ward managers could have been more visible for patients. Patients did not know who the manager was and said they would not recognise them.

Are medical care services well-led?

Requires improvement



We rated well-led as requires improvement because:

- A clinical governance framework was in place however, it needed further development in some specialties to ensure effective scrutiny of issues and ensure learning was achieved.
- Clinical leadership was variable due to the inexperience of some staff, the high levels of temporary staff and high levels of staff turnover.
- Senior leadership within medical services had been strengthened but some of the staff were new into post and there had been limited time to effect change.

However:

- There was good public and staff engagement in the improvement and development of services.
- There had been improvement in services since the last inspection and there was a good understanding of the challenges still remaining.
- The service were taking forward a range of initiatives in collaboration with other stakeholders to improve and sustain services.

Leadership of service

Vision and strategy for this service

- The trust was part of the "Transforming Services Together" programme in partnership with commissioners and other local healthcare providers. The aim was for Whipps Cross Hospital to provide an acute care hub which would bring together the clinical areas of the medical divisions that focused on the initial assessment and stabilisation of acutely ill medical patients and service developments reflected this.
- The service was also implementing an action plan which contributed to a flow improvement programme to facilitate the effective use of resources and improve patient experience from referral to discharge.
- The trust was undertaking clinical engagement events involving stakeholder partners and agencies to explore the future development of services on the Whipps Cross Hospital site. This was in order to develop a strategic

Medical care (including older people's care)

outline case for the redevelopment of Whipps Cross Hospital into a Health and Social Care Campus providing fully integrated services. This would shape the future of medical services at the hospital.

- The senior leadership team told us the initial focus was to improve services on the ground, focussing on staffing and embedding the compassionate care improvement plan.

Governance, risk management and quality measurement

- Site based quality meetings were held monthly for all specialties within medical services. We reviewed the minutes of these meetings and talked with the senior leadership team about the content and format of the meetings. The governance arrangements had been strengthened since the introduction of the site based management structure but there was still work to be done to ensure there was consistency of approach across specialties and sufficient scrutiny and discussion of issues. For example, the notes of some meetings suggested a process driven approach to incidents and mortality and morbidity reviews whilst others demonstrated there was a discussion of the specific issues and learning points identified.
- Safety huddles and safety briefings enabled escalation of issues and facilitated the dissemination of learning to ward staff. We also saw examples of, "Learning from..." documents which were A4 handouts used to disseminate learning from incidents.
- Quality performance data was displayed on noticeboards on medical wards and staff were aware of their performance against key quality priorities such as the prevention of pressure ulcers, falls and infection prevention and control targets.
- Communication between the trust wide governance structures and committees and the site based clinical management teams was not always effective. We were told there were no action plans resulting from most of the national audits in medicine but the local management team produced action plans which had been developed.
- Risks identified by the inspection team during the inspection visit and by staff at clinical level were not always reflected in the risk register. For example, the environment of the haemodialysis unit and Elizabeth Ward.

Culture within the service

- Staff said they felt they were listened to and senior staff and managers were supportive. A consultant said there had been a culture change and they had seen improvement month on month.
- We were told safety issues were given a higher priority and were being addressed. One person said, "There has been a focus on what was going wrong and things are so much better." "Thank goodness, at last!" Another person said, "We have finance meetings and have to think about how we spend the money, but we are told we shouldn't compromise safety."
- We found staff were keen to demonstrate the improvements which had been made whilst recognising there was further work to be done.
- A therapist commented that the way therapists were seen in the trust had changed and their role was better understood and valued. They said there was a focus on retaining staff.
- Junior doctors also said they felt part of the team and well supported. They said they could always contact more senior doctors and consultants for advice if required.
- However, we also received some comments about variable team working and the culture of compassionate care which was being promoted was not consistently embedded.

Public engagement

- We found examples of patient and public involvement in many of the developments within the service.
- The diabetes service had involved patients in the development of various aspects of their service including the new diabetic foot pathway for inpatients, the young people's clinics and community diabetic pathways.
- The dementia strategy group membership included the relative of a patient who had made a complaint and representation from the trust patients' panel.
- A survey had been undertaken to examine patient experience within the ambulatory care unit and the results indicated a positive experience overall.
- The trust were utilising a rating website to collect patient feedback and display boards in the wards provided feedback on action taken as a result of feedback.

Staff engagement

Medical care (including older people's care)

- Senior staff within medical services talked about the “Listening into Action” groups which the trust’s organisational change team were using to enable staff and patients to contribute their views and influence the changes and developments to services.
- We saw a flyer for a Listening into Action group which was to be held for the Dementia Friendly Environment Project, involving improvements to five wards to make them more dementia friendly and welcoming for patients.
- Staff we talked with felt they were being listened to and as a result felt they could voice their opinions and were engaged in improving services.







Innovation, improvement and sustainability

- A medical consultant was at the forefront of developments to management of TB in the locality, chairing the North East London TB sector and attending quarterly meetings with NHS England. She was part of a University College London quarterly research based group.
- The Early Inflammatory Back Pain Service (EIBPS) at Whipps Cross was introduced to improve referral quality and reduce the delay to diagnosis for axial spondyloarthritis (axSpA). Care was coordinated by a specialist physiotherapist supervised by a consultant and had resulted in high levels of patient satisfaction. Educational materials had been produced, which could be employed elsewhere in the country to raise awareness of inflammatory back pain in the community and primary care.
- A number of developments had been introduced in the diabetes service at Whipps Cross hospital. These

included a multi-disciplinary surgical-endocrine radiology MDT to review adrenal and parathyroid cases pre- and peri-operatively, and an adolescent diabetes clinic run jointly with the paediatric diabetes team to improve transition to adult diabetes clinics alongside other developments noted above to respond to the needs of the local population.

- The dementia team had been strengthened since the last inspection and the implementation of the dementia strategy progressed. Charitable funding had been obtained and there was a plan for the refurbishment of five medical wards to provide a “Dementia Friendly Environment.” A programme of dementia awareness training had been developed and was being rolled out across medical services. The carer’s strategy had been re-launched and changes introduced to enable carers to be recognised and involved in the patient’s care if they wished. Volunteers were being trained as dementia “buddies” to engage with people with dementia.
- Staff and managers within medical services spoke very positively about the changes which had occurred over the last year using words such as “considerable progress,” and “massive change.”
- Patients also told us of the “huge improvement in the hospital,” with a patient saying they had been an inpatient at the beginning of the year and were “amazed at the difference.” They said there was a big improvement in the care provided. Another patient said they felt the hospital had, “Come on in leaps and bounds,” saying they had been treated really well and felt well looked after.

Surgery

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

Information about the service

Whipps Cross University Hospital provided a range of elective (planned) and emergency surgical services to the local population, including orthopaedics, general surgery, vascular surgery, colorectal surgery, urology, trauma, ear, nose and throat (ENT) and ophthalmic surgery. In the 12 months prior to the inspection, 14,053 operations had been carried out. The most common operations were ophthalmic (3,262); trauma and orthopaedics (3,237) followed by general surgery (2,140).

There were 13 operating theatres, two of which were specialist orthopaedic and one designated trauma theatre that operated 24 hours a day, seven days per week. There were two ophthalmic theatres, which were used for specialist eye surgery.

At the time of our inspection, there were approximately 150 surgical beds in the designated surgical wards and 29 patients could be accommodated on the surgery day case ward. We visited Hope Ward (elective assessment), Poplar Ward (short stay surgery), Primrose Ward (male ward), Rowan Ward (female ward) head and neck, Sage Ward (elective orthopaedic), Sycamore Ward (emergency orthopaedic) and Plane Tree Ward (surgery day case).

During our inspection spoke with 25 patients, observed care and treatment and looked at 31 care records. We also spoke with 86 staff members at different grades, including allied healthcare professionals (AHPs), nurses, health care

assistants, doctors, consultants, ward managers, matrons and members of the senior management team. In addition, we reviewed a number of documents such as meeting minutes, audits, and performance and quality data.

Surgery

Summary of findings

We rated this service as inadequate because:

- The incident reporting process was inconsistently applied. We found limited evidence of learning from incidents or complaints.
- Surgical site infection data was not effectively captured and used to inform the service and drive improvement.
- Nursing staff were concerned about the quality of the agency nurses and gave us examples when this compromised patient's care and treatment.
- A number of nursing staff in different surgical areas told us about ongoing issues of bullying and harassment. They were visibly distressed and told us they did not feel supported by their managers and service leaders. They felt the trust was not supportive of whistle-blowers. They gave us examples when they were blamed for and unprofessionally treated after raising an issue or a complaint. Nursing staff felt they were not valued, appreciated or recognised.
- Surgical services did not have well embedded working relationship with the infection prevention and control team. There was also poor communication and understanding between the wards, recovery and acute assessment unit in relation to handovers.
- There was evidence of poor in-hospital patient transfer practices where patients' infectious status was not always handed over.
- Theatre utilisation was low due to late starts, delays between cases and early finishes. We found the timing of theatre list and available supportive services such as radiology meant the theatres were almost destined to start late. This occasionally led to on-the-day cancellations.
- Despite having a very diverse local population we did not see leaflets available in any other language apart from English.
- Not all patients were screened for malnutrition as required by NICE guidelines.

- We saw little evidence that local clinical and quality audits were regularly carried out. Specialist surgical clinical governance meetings (apart from theatres) were not well embedded, poorly attended and some were not represented by service leads. Not all risks were captured on the risk register.

However:

- We found staff to be committed, dedicated, caring and motivated to deliver care and treatment to patients. Most patients we spoke with told us their experiences of care were positive, staff were caring and professional.
- Morning and evening handover at shift change were relevant and focused on patient care and safety. Nursing staff carried out regular intentional roundings.
- The surgical services worked towards reducing hospital-acquired pressure ulcers with the surgical wards achieving good results.
- Wards had a direct access to nutrition and dietetic services and we saw nursing staff appropriately referred patients to a dietitian.
- Patients' pain was assessed and managed effectively.
- Staff attended a daily safety huddle to enhance patient safety across the hospital.
- The service introduced a 'joint school' initiative for orthopaedic patients undergoing joint replacement surgery to improve their recovery after surgery.

Surgery

Are surgery services safe?

Inadequate



We rated safe as inadequate because:

- There was ineffective use of the electronic incident reporting system with little evidence of learning from the incidents. Staff, including senior managers and leaders did not know about a recent never event. Nursing staff had limited opportunities to discuss and analyse serious incidents with medical staff.
- None of the surgical wards were compliant with the trust's target for the completion of venous thromboembolism (VTE) assessments.
- There was no reliable system to collect surgical site infection data. As such, the surgical services did not know how many wound infections occurred following surgical procedure.
- There was limited involvement of the infection prevention and control team (IPC). The IPC team was not routinely informed about infections and wounds that happened within the service. The IPC team was not represented at the mortality and morbidity meetings.
- We observed a number of infection control issues related to the operating theatre environment. Surgical staff wore theatre scrubs and clogs unchallenged across different areas of the hospital. This increased the risk of infection to patients undergoing an operation.
- Patients' infectious status was not always handed over to staff from other wards/units.
- Nursing staff on wards did not have a blood lactate testing equipment to monitor septic patients and had to use one in other areas of the hospital. This caused delays in providing patient care.
- Nursing staff on the wards were often interrupted when dispensing drugs because for example they were required to attend medical ward rounds. This increased the risk of medication errors or delays to patients getting treatment.
- We observed staff were retrospectively completing patient records during a handover. We did not see evidence that nursing documentation was regularly audited. We saw one nursing documentation audit carried out in June 2016 which included only two surgical wards.

- Not all staff groups across surgical services complied with safeguarding training completion rates. There were poor completion rates of medical gas safety training, infection control Level 1, 2 and 3 and blood transfusion training across different staff groups.
- The operating surgeon in the emergency theatre was not always present when a patient was anaesthetised therefore they missed 'sign in' stage of the surgical safety checklist.
- The use of agency staff on some the wards was between 50 and 70%. Nursing staff told us they were concerned about the quality of the agency nurses and gave us examples when this compromised patients' care and treatment. Substantive staff told us they felt under significant pressure when working with the agency nurses.
- There was limited surgical cover at nights and surgical staff did not always attend the Hospital at Night team meetings.
- On-call doctors were also carrying out ward rounds and frequently had to leave half way through the round if they were called to theatres.

However:

- Staff we spoke with knew how to report an incident, including near misses. Morning handovers began with a safety brief where staff learned about recent incidents.
- We saw evidence that Duty of Candour (DoC) was applied when a notifiable safety incident occurred.
- The surgical services put a lot of emphasis on reducing hospital-acquired pressure ulcers with the surgical wards achieving good results.
- We observed most wards, recovery areas and operating theatres were clean. Hand washbasins and alcohol hand sanitising gel were easily accessible and used.
- Resuscitation equipment in theatres and on the wards for use in an emergency was readily available.
- Staff regularly checked and recorded fridge temperature and we found these were within a safe range. Equipment in theatres, recover areas and on wards that we checked were all PAT inspected and safe to use.
- Medicines, including controlled drugs (CDs), were securely stored, dispensed and disposed of by staff.
- Staff we spoke with knew how to report safeguarding concerns.
- Nursing staff carried out intentional rounding and we observed nursing staff on wards appropriately escalating deteriorating patients to medical staff.

Surgery

- Results from the 'five steps to safer surgery' audit between February and July 2016 showed 98-100% compliance with the process.
- Morning and evening handover at shift change were relevant and focused on patient care and safety.

Incidents

- The surgical service had an electronic system, Datix, to report, investigate and act upon incidents and adverse events. However, this was not always effectively or consistently used. Between May 2015 and April 2016, surgical staff reported 1,269 incidents. The majority of the incidents related to delays in care (157), pressure ulcers (151) and communication (123). Of 1,180 incidents that were reviewed and approved by managers, 553 did not have any lessons learned recorded. Also, we reviewed a sample of the recorded lessons learned and some did not indicate any learning points and only stated 'well done' or 'thank you'.
- During the inspection, we saw staff did not report an incident related to infection control. When asked they told us 'it did not cross their mind to report it'. Another staff member told us they did not report being understaffed as this happened so regularly that they would constantly have to report it.
- Most staff we spoke with told us they knew how to report an incident and gave us an example of reporting one. They told us they received feedback through Datix after reporting an incident. Staff also told us they reported 'near misses' (a prevented patient safety incident) and showed us examples.
- Seventeen serious incidents (SIs) were reported between August 2015 and July 2016, 13 of which were grade 3 or grade 4 pressure ulcers. We saw two examples of completed SI investigations which were completed according to the principles of root cause analysis (RCA). The reports outlined lessons learned and had action plans to prevent future incidents.
- Nursing staff told us following an SI there was a safety briefing where staff discussed the incident. However, staff told us they did not always receive a formal feedback following an SI investigation and they did not have the opportunity to discuss and analyse an incident with medical staff. Medical staff gave us example of recently reported an SI and showed evidence of learning and changes in practice.
- Never events (NEs) are serious incidents that are wholly preventable as guidance or safety recommendations

that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Initially the trust told us there were no NEs reported by surgical services at Whipps Cross University Hospital. We found most staff were aware of NEs that happened across the hospital and they described the incidents to us. Wards had folders which listed all NE in 2015/16 for staff to review. However, after the inspection the trust confirmed that there was one NE related to a hip replacement on a trauma patient. None of the staff, including service leaders, we spoke with told us about this safety incident.

- Staff morning handovers began with a safety brief where staff learned about recent incidents. Staff had an opportunity to discuss incidents during monthly ward meetings, however we were told the meetings were not always happening every month.
- There was a monthly mortality and morbidity meeting. It was a half-day meeting where all theatre activity (apart from emergency) stopped to allow staff attend it. The meetings were well attended by all levels of medical staff. However, we were informed there was no representative from the infection prevention team.

Duty of Candour

- The Duty of Candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person. Staff we spoke with had an understanding of the DoC. They gave us examples of when they applied the principle of the DoC by apologising and being open and transparent with patients and their families. The examples related to hospital acquired pressure ulcers and patient care.
- Senior staff explained us the DoC process after a notifiable safety incident occurred and showed us examples when this process was followed. This was in line with the trust's policy. The process included informing the patient and their relatives about the incident, providing support, information and apology. Patients or a relevant person, were also invited to the outcome meeting following an investigation.

Safety thermometer

Surgery

- Between April 2015 and April 2016, the surgical service reported 59 pressure ulcers (grades 2, 3 and 4), 37 falls with harm and 24 catheter acquired urinary tract infections.
- Wards used safety cross boards located at the entrance to the ward to note patients fall, incidences of pressure ulcers, cardiac arrests, environmental audits and hand hygiene.
- We saw in various meeting minutes the wards were working towards reducing hospital-acquired pressure ulcers (PUs). During the inspection, there were no PUs on Rowan Ward, no PUs on Poplar Ward (one PU the month before), while Sage Ward had 230 PU-free-days for which they received a certificate of recognition.
- Staff told us they put emphasis on PU care by screening and identifying patients at risk, looking at additional health issues, reinforcing gaps during safety brief and carrying out detailed bedside handovers. Pressure care was also discussed during a staff handover. Additionally, senior staff completed an investigation for all PUs with lessons learned shared with staff during monthly ward team meetings.
- Patients at risk of fall were allocated a health care assistant, although staff told us this did not always happen due to staff shortages. The trust told us they had introduced enhanced care to the wards and this was being trialled at the time of inspection. This involved cohorting patients and use of carers and family in the care of patients. The trust said they advanced book one to one nursing care for “at risk patients” and moved staff to accommodate needs of patients to ensure safety.
- The trust’s venous thromboembolism (VTE) screening target was 95% and staff was required to complete a paper-based and electronic assessment records. An audit carried out in November 2015 and January 2016 showed the compliance with the paper and electronic VTE assessment was very poor across all surgical wards. All wards achieved 57% and 42% compliance respectively for paper-based assessments (electronic records were even lower 35% in November 2015 and 46% in January 2016). Most recent data provided by the trust from June 2016 showed the completion rates on the wards improved and the rates were between 59% and 85%; however, this was still below trust’s target of 95%.
- Senior staff told us Sycamore Ward was dedicated to emergency orthopaedics and Sage Ward was for elective (planned) orthopaedics patients. However, we found the wards had a mixture of emergency and elective orthopaedic patients as well as a number of other surgical specialties and medical care patients. This is not best practice, as has a potential to increase patients risk of infection.
- Surgical site infection (SSI) is a type of healthcare-associated infection in which a wound infection occurs after an invasive (surgical) procedure. The 2014 inspection highlighted that SSI rates were not counted or reported. During the current inspection, we found the SSI data collection was substandard due to poor completion of SSI forms by theatre staff, incorrect use of surgery code, incorrect data recorded, and poor follow-up of patients. We saw ‘Surgical Site Infection’ meeting minutes from July 2016 when staff started to work on a plan to address this gap however, at the time of the inspection there was no reliable system in place to collect the data.
- During our visit we observed a patient who was barrier nursed (‘barrier nursing’ occurs when a patient is kept in a bay and extra precautions are implemented to prevent spread of the infection). We reviewed the trust’s isolation policy however; the policy did not include information on barrier nursing of the patient in a bay.
- A number of staff told us the level of involvement of the infection prevention and control team was limited. A staff member told us they “hardly know they exist”. Some staff told us they never involved the infection control team when treating a new infection as the team offered a late input to the ongoing infection issues. Another member of staff told us they would like the infection control team to give more input and offer solutions “rather than just pointing issues out that they were already aware of.”
- There was no formal channels in place to automatically inform infection prevention control team about infections and wounds. The team learned about these if a microbiologist or doctor informed them but this did not routinely happened.
- During the inspection, we observed a number of surgical staff moved between different areas of hospital (canteen, meeting rooms and wards) in theatre scrubs and theatre clogs without overcoats. This increased the

Cleanliness, infection control and hygiene

Surgery

risk of infection for patients undergoing an operation. A member of infection control team told us staff were allowed to wear theatre scrubs and clogs only when moving between the theatres.

- We observed a number of infection control issues related to the operating theatre environment such as small pieces of loose plaster and exposed plaster on the walls in theatres, staff using clipboards made of medium-density fibreboard (MDF), chipped work surfaces with exposed wood, lifting floor panels, and a ripped mouse pad.
- On few occasions, we observed staff did not adhere to the infection prevention standards and protocols. For example, on two occasions we observed staff using their mobile phones in clinical area (theatre and ward). We observed a porter left their drink on patient's locker when they came to collect a patient. We observed staff handling patient's urine without gloves. Also, we observed a number of staff had dirty and stained uniforms.
- We saw an incident when a patient's infectious status (such as MRSA or diarrhoea) was not handover by staff from another ward/unit. As a result, the patient was initially located in a bay with other patients which put them at risk of infection. Ward staff told us poor handover such as this happened frequently.
- We observed most wards, recovery areas and operating theatres were clean. All staff and patients we spoke with told us the cleanliness on the wards was good.
- Deep cleaning of theatres was done every six months. Staff told us the quality of deep cleans was poor with staff rarely sign off the cleaned area the first time. We asked for evidence of deep clean audits of theatres however, we were not provided with any.
- Hand washbasins and alcohol hand sanitising gel were easily accessible at ward and theatre entrances and the hand gel was available by each bed. Instructions for their use was clearly displayed next to and on the soap/alcohol dispensers. We observed staff adhered to the hand hygiene and 'bare below elbow' standard.
- The monthly infection prevention control audits, which included hand hygiene and catheters, did not always happen. Information submitted by the trust between April 2015 and April 2016 showed the wards did not have the data on at least four occasions or more (with Hope ward missing eight months' data) out of the 13 months. The results showed that when audits took place most wards achieved the trust's target of 90%. The exception

was Primrose Ward which scored below trust's target on six out of eight hand hygiene and catheter audits achieving between 60% and 80%. Also, Rowan Ward scored 60% and 80% on four out of seven hand hygiene audits.

- We observed on a number of occasions nurses challenged and reminded staff to wash their hands or use hand gel on entering the ward.
- The service used disposable curtains which we saw were in date.
- Surgical service had two hospital acquired MRSA cases, and no *Clostridium difficile* (C. Difficile) infections between April 2015 and March 2016. Investigations of the two MRSA cases concluded they were avoidable. Between October 2015 and April 2016 screening for MRSA on wards was below trust target of 100% and was between 72% and 88%.
- Screening for MRSA and C. Difficile of elective patients was done during pre-operative assessment. This was valid for three months and had to be repeated if a patient was not seen within this period. Information about MRSA, C. Difficile infections and cleaning audit were displayed on the ward for staff and patients.
- We saw staff used 'I am clean' stickers to indicate equipment was cleaned and ready for use.

Environment and equipment

- Resuscitation equipment in theatres and on the wards for use in an emergency was readily available, well stocked and we saw evidence of daily checks carried out by staff.
- We saw evidence anaesthetic machines were regularly checked by staff.
- Machines in recovery had a continuous capnography (the monitoring of the concentration or partial pressure of carbon dioxide in the respiratory gases).
- We saw evidence that staff regularly checked and recorded fridge temperatures and the temperature in anaesthetic rooms and that they were within a safe range.
- At the time of the inspection, the store rooms we checked had an adequate stock of sterile instruments and consumables. However, staff on a ward told us restocking was an issue and they frequently ran out of consumables such as gloves, catheter tips or syringe needles which they had to borrow from other wards. They told us this caused unnecessary delays in treatment.

Surgery

- Nursing staff on wards told us they had a number of patients with sepsis however they did not have a blood lactate testing equipment, a device used in monitoring septic patients. The hospital had designated areas (primarily in ED, theatres and ITU) where blood gas analysers were located to obtain a lactate result. However, since the areas were some distance away from the wards staff said this led to delays in providing care and treatment.
- All medical staff we spoke with told us they had the equipment and facilities to deliver care and treatment to patients.
- Theatres had a staff member who looked after the equipment and staff told us they were 'invaluable' in maintaining it. Faulty medical equipment was labelled as 'out of service' and sent to a medical engineering team responsible for its maintenance. Staff told us the service was usually good.
- Equipment in theatres, recovery areas and on wards that we checked were all safety tested and labelled to ensure they were safe to use. Equipment was also in date with regards to maintenance by either in house Electro-Biomedical Engineering (EBME) department or external suppliers.
- The hospital had two computerised tomography (CT) scanners which staff told us occasionally broke down. In the past three months, one or the other scanner broke down on eight occasions. A staff member told us there were occasions when both scanners were not working. However, assurance of a number of staff and data provided by the trust showed there were never occasions when both scanners were not functioning and this had never affected the delivery of care and treatment to patients. Staff told us there was a business continuity plan to mitigate such risk. However, this risk was not listed on the local risk register.
- Willow Lodge, pre-operative assessment, was located in a 20 years old temporary building which staff told us was beyond 'sell-by date' considering the volume of work and high patient through-flow. Staff told us there were no plans to relocate. The area required some maintenance work and staff told us there had not been any re-decoration done for at least three years.
- CQC inspection in 2014 highlighted issues around safety and compliance with relevant regulations within operating theatres 1, 2, 3 and 4. During our visit staff told us operating theatres 1 and 2 were due to be decommissioned and moved to the newly built

operating theatres 11 and 12. Also, emergency operating theatres 3 and 4 were upgraded since the last CQC inspection in 2014 and were now compliant with relevant regulations.

- We asked the hospital for the annual maintenance and revalidation checks of operating theatres ventilation. The trust provided us with the annual maintenance schedule and it was not clear what the outcomes of these checks were. Although we did not have any concerns regarding the ventilation during the inspection, we were not provided with the evidence to assure us the ventilation was safe for patients undergoing surgical procedures.

Medicines

- We observed there was no system in place to indicate to staff that a nurse was busy dispensing drugs on the wards by for example wearing a drug apron/pinnies. Drug pinnies are used to indicate a nurse is busy which reduces the number of interruptions during a drug round. This helps to improve patient safety by reducing incidence of medication errors. Staff told us they were often interrupted because for example they were required to attend medical ward rounds.
- Medicines which required being stored at a low temperature were kept within a medicines fridge. We saw evidence temperatures were checked and recorded daily, and these were within the expected range.
- Controlled drugs (CDs) were securely stored in lockable units, daily checked and appropriately signed for. We checked a sample of CDs and these agreed with the CD register.
- All drugs we checked were in date.
- We observed drugs management, administration and disposal was generally good across all clinical areas. The inspection team reviewed medicine storage in recovery areas and wards. Medicines were mostly stored securely in a locked room. However, we observed a drugs trolley that was stored in a room with a lock 'on latch' therefore not secured.
- We noted that some medication storage rooms were warm. On one ward, the temperature was 28 Celsius degrees. Staff told us this had been escalated to estates and there was a plan for a new clinical room with more ventilation. One room was fitted with a portable air-conditioning unit to keep the temperature down. The issues with the temperature were not added to the local risk register.

Surgery

- Staff told us there were issues with obtaining 'To Take Away' (TTA) discharge medicines as there were problems in getting timely prescriptions. Staff tried to get doctors to write them up a day before a discharge however, this did not always happen. The wards did not have TTA recording book.
- Staff told us they receive inconsistent pharmacist support. They told us they did not have a designated pharmacist for the greater part of the year which had led to discharge delays.
- An antimicrobial key performance indicators (KPIs) audit completed in December 2015 showed the average compliance was between 70% and 90% for three out of four indicators falling below the 90% target. These KPIs related to the documentation, duration/stop or review date, and clinical team reviewed. Compliance with the fourth indicator which related to the adherence to local guidelines was good (96%).

Records

- Staff on the wards told us sometimes they had to stay after they finished their shift to complete patient notes. We observed staff were retrospectively completing patient records such as Waterlow score (pressure ulcer risk assessment tool), access to toilet care plan or the administration of medication, during a handover.
- During the inspection we saw most staff complied with information governance standards. Patient records were stored securely inside notes trolleys that were secured with locks. In addition, staff signed off computers when they were not in use. However, on two occasions we observed medical staff accessing patient notes and leaving them out. We addressed this with the ward sister who said they were aware of the issue and told us they would address it. We also observed patient records left in an unlocked cabinet in a room with easily accessible to public. We brought this to the attention of staff that then locked the room and explained this had never happened before. However, we observed the same situation the next day.
- We reviewed 31 patient records across different surgical sites. We found the records to be clearly written and dated with legible signatures. Most of the patient records were comprehensive and thorough. Patients had their care needs risk assessed and appropriately recorded with risk assessments completed, such as MUST, fluid balance, falls prevention, acute pain management and skin bundle.

- The nursing documentation audit in June 2016 showed Rowan Ward achieved 67% and Sage Ward achieved 100% compliance against trust's target of 100%. Other surgical wards were not audited and it was not clear what improvement plans were in place for Rowan Ward.
- Preoperative assessments were undertaken before the day of the procedure. The assessment was valid for a maximum of three months in case procedures were delayed or cancelled.

Safeguarding

- Safeguarding adults level 1 and 2 training was completed online and repeated every three years. All nursing and medical staff were required to complete level 2 safeguarding training while senior staff safeguarding children level 3. There was no safeguarding adults level 3 training available to staff.
- The training data provided by the trust for the service showed completion rates of 90% or more for safeguarding adults level 1 and level 2 training for most nursing and administrative staff. Completion rate for safeguarding children level 3 training was 100%. However, medical staff in different specialities had been identified as falling below the trust's target of 90% for safeguarding adults level 2 training with reported rates between 39% and 80%. Also, compliance with safeguarding adults level 2 training on Rowan Ward for nursing staff was 65%, and 86% for ophthalmic theatre nursing staff.
- Staff we spoke with were familiar with the safeguarding arrangements. They told us they knew how to make a safeguarding referral and gave us examples of reporting a safeguarding concern. Staff told us they received feedback following a safeguarding referral.
- Staff told us after completing a safeguarding referral they followed it up with an incident form completed on Datix system. A review of incidents reported in surgery between January 2015 and April 2016 showed that eight safeguarding adults and children concerns were recorded on Datix. This low number of incidents indicates staff did not always follow the trust's safeguarding policy which requires staff to complete a Datix form.
- All theatre staff completed female genital mutilation (FGM) training within the last year.

Mandatory training

Surgery

- Statutory and mandatory training booklets were provided to new staff who were required to read them. Some training was classroom based but staff told us majority of learning was delivered either by booklet or eLearning. A number of staff told us they preferred booklet style learning due to IT issues and because it was 'easier and faster'. However, some staff questioned how much information they were able to retain through reading a booklet.
- The mandatory training compliance rates mostly reached the trust's target of 90%. Although most areas and wards were achieving this, there were some trainings where staff fell below this target. This included:
- Medical gas safety training where most nursing and additional clinical staff on wards did not meet the target achieving between 0% and 87% completion rate.
- Infection Control Level 1, 2 and 3 training where completion rates in different surgical areas and wards (general surgery and urology medical staff, pre assessment and theatre staff and Sycamore Ward nursing staff) did not reach trust's target and were between 66% and 88%.
- Blood transfusion where completion rates in different areas and wards (general surgery and urology medical staff, pre assessment and theatre staff and Sycamore Ward nursing staff) did not reach trust's target and were between 66% and 86%.
- There was a good completion rate of '4 Harms' training which included VTE, falls, pressure ulcer prevention and catheter acquired infections. All nursing staff on the wards met the trust's completion target of 90%.
- Training rates of early warning system (EWS) training (used to identify deteriorating patients) were above 92% across all wards except additional clinical staff on Sage Ward whose compliance rate was 83%.
- There was a local induction programme for newly appointed staff. New agency staff had to complete induction which included orientation and introduction to the environment. There was a local induction checklist for agency nurses that had to be completed before they started their shift. We saw written evidence of this.

Assessing and responding to patient risk

- The surgical wards used the national early warning score (NEWS) system for standardising the assessment of acute illness severity. We found NEWS forms had clear directions for escalation and staff were aware of how to

identify and what action should be taken if patients scored higher than expected. We reviewed a sample of patient notes on different wards and observed NEWS were correctly used and scored.

- NEWS audit data between December 2015 and March 2016 showed between 71.6% to 95% compliance across Poplar, Primrose, Rowan, Sage and Sycamore Wards against the target of 80%. Rowan and Sycamore Wards performed worse, failing to reach the trust's target in two out of four months.
- Nursing staff carried out intentional roundings (a structured process where nurses carry out regular checks with individual patients). We saw this took place and it was documented in patient records. Patients confirmed nurses regularly visited and carried out checks on them.
- We observed nursing staff on wards appropriately escalating deteriorating patients to medical staff.
- Various risk assessments such as those related to falls, skin integrity and nutrition, were carried out on admission. We saw these were being recorded in patient notes.
- The theatre staff completed safety checks before, during and after surgery as required by the 'five steps to safer surgery' procedures. However, there was no pre anaesthetic surgery team brief in emergency theatres. Staff told us this was due to different teams being involved in each case.
- We were told and observed that in the emergency theatre the operating surgeon was not always present when a patient was anaesthetised. This meant a doctor was not always present during the 'signing in' stage of WHO surgical safety checklist and the anaesthetist had to liaise with a surgeon after the patient was moved to the theatre. We saw example of team waiting approximately 15 minutes for a surgeon after a patient was anaesthetised.
- We observed good standards of practice at induction of anaesthesia with pre-induction checks, monitoring and anaesthetic agent induction done in line with the national standards.
- We observed the WHO surgical safety checklist practices which were thorough, with all stages clearly verbalised and theatre staff engaged. All stages were well embedded and in line with national standards. Surgical teams communicated well and were clear about their roles. We observed a staff member who led the checklist

Surgery

challenged others if they were not fully engaged.

Although recovery staff were not always present during the sign outs, we observed an adequate handover was done in recovery.

- Results from the monthly quality observational 'five steps to safer surgery' audit between February and July 2016 showed 98-100% compliance with the process. Each month 90 to 100 audits were completed. The few issues highlighted by the audit related to medical staff leaving the theatre before the debrief (six cases) or not being present during the brief (two cases). Any non-compliance with the safety checklist was reported to team leaders.
- Staff in recovery were unhappy about having to function as an intensive care/high dependency unit (ICU/HDU) 'overflow facility'. Seven theatre staff members received critical care training. The trust told us majority of staff in this staff group completed advance life support (ALS). Staff told us safety risks were mitigated by having an anaesthetic trainee present for level 2 cases. Twelve anaesthetists were trained in ALS. The trust was unable to tell us what percentage of anaesthetists that was. The trust told us in the last year 52 patients stayed overnight in recovery that were identified as needing HDU/ITU beds. None of the patients stayed more than one night.
- The trust had identified that a large volume of patients were remaining in the recovery for an extended period of time due to: lack of critical care bed or delay to availability of critical care bed, and lack of ward bed. Trust told us elective admissions were discussed at regular capacity meetings, and they had introduced the surgical manager of the day who worked in partnership with the clinical site manager, senior nurse, anaesthetists and the consultants for critical care to address this issue.
- Trust told us in the last 12 months 846 day case patients stayed overnight despite a "no overnight stay" management intention. The service did not collect the reasons for the conversion to an in-patient which was a missed learning opportunity.

Nursing staffing

- During the inspection, senior staff told us the use of agency staff on some of the wards was 50-70%. Data provided by the trust showed that between April 2015 and March 2016 the use of agency/bank staff was on average as follows: 54.3% in orthopaedics, 45.1% in general surgery, 20.6% in ophthalmology, 16% in

pre-assessment, 6.3% in ear, nose and throat, 0.8% in urology and 0% in oncology. Senior staff told us they had a rolling recruitment programme but they struggled with the recruitment.

- Senior staff told us agency nursing staff were mainly used during night shifts, as day shifts required more experienced staff. Senior staff told us they tended to use the same agency nurses and they communicated with the nursing agency to ensure the nurses who performed below required standards did not return to the hospital. Senior staff told us they felt comfortable with the agency nurses as most worked regular shifts on the wards.
- However, nursing staff told us they rarely saw the experienced nurses return, instead they worked with agency staff who were less skilled. Staff told us they used to be able to pre-book agency nurses that were good, but due to costs the trust preferred to wait until the shift was filled by bank staff.
- Nursing staff told us staffing levels were not an issue but their concern was about the level of competence of the agency staff. They were concerned a number of experienced staff had left and continued to leave while they increasingly had to work with agency nurses who often were less experienced, had poor attitude and work ethics. Senior staff told us the main reasons for complaints made against agency staff were poor timekeeping, lack of professional attitude or capabilities, and unkindness towards patients.
- Substantive staff told us they felt under significant pressure when working with the agency nurses. We were told about a number of incidents when agency nurses did not turn up for a booked shift or arrived late. We saw a number of incidents when nurses came late for their shift, missing most of the staff handover meeting.
- Substantive staff told us working with agency staff had a significant impact on their work as they had to closely supervise them or complete tasks they refused to do, while carrying clinical caseloads of a bay of six or seven patients. They often allocated agency nurses to patients who did not require complex care which meant they had complex workload as well as being in charge of a shift. Staff said they tried to maintain safety as much as possible but were concerned about the impact it had on patients' care.
- Substantive staff told us nights were particularly difficult as occasionally they only had agency nurses to work with. One nurse described such arrangement as 'chaotic', 'scary' and 'very stressful'.

Surgery

- Medical staff told us the quality of the nursing staff was held back by the large number of agency nurses who often changed and needed additional support from the permanent colleagues.
- We were told planned staffing levels on surgical wards during day shifts were five registered nurses and four or three band 2 healthcare assistants with a supernumerary band 7 ward manager covering weekdays. Ward staff rotated at night to take charge of the shift. To ensure safe staffing numbers on the wards, senior managers often had to try to move staff from other sites within the hospital. However, nurses told us and we saw incident reports where staff had reported feeling bullied or intimidated by managers into sending nurses or HCAs to work on other wards. This added additional pressure on the nurses' workloads, who sometimes worked without a break.
- Sickness rates data provided by the trust showed sickness rates on the wards were between 3% and 6%.
- Apart from matrons and ward managers/sisters, nursing staff and health care assistants were difficult to identify and distinguish as they had varying uniforms. Patients told us they often did not know what was the role of a staff member they interacted with.
- The acute assessment unit (AAU) where emergency surgical patients were triaged had a high rate of unfilled band 5 nurse vacancies (45 vacancies out of 50). This was mitigated by the use of bank and agency nurses however staff told us this caused stress and required their additional input to maintain high standards of care.
- We saw rotas and observed that theatres and recovery areas had safe staffing level which met the Association for Perioperative Practice (AfPP) guidelines.
- Data provided by the trust showed that between April 2015 and March 2016 the use of agency/bank staff in theatres was 12.4%. Senior staff told us they tried to match agency staff to the complexity of patient's care and they did not use agency nurses at nights. A number of staff told us theatres had a steady workforce and they used regular agency staff who were reliable.
- The wards used staff boards to clearly indicate nurses' bed allocation and individual responsibilities for patients.
- Morning and evening handover at shift change for all nursing staff was either in staff room or at patient's bedside. After this, nurses and HCAs were allocated to specific patients and received second handover at the

bedside for each individual patient they were caring for. We observed four handover meetings and we found them to be relevant and focused on patient care and safety. Staff discussed patients in details, highlighting current issues such as safeguarding, mental capacity, risks, treatment, care plans and discharge arrangements. Also, staff demonstrated good knowledge of the patients they were looking after.

Surgical staffing

- Medical cover was split between the wards and emergency department for the surgical services. Surgical consultants reviewed patients in the AAU.
- During the day the wards were covered by junior and middle grade doctors, and were supported by an on-call middle grade doctor and a consultant for that day covering and supporting the inpatient wards for their speciality.
- Staff we spoke with told us there was an on-site consultant cover during the day, five days a week, as well as an on-call service at weekends. Emergency services were delivered by senior medical staff in-hours. Consultants also attended patients out of hours depending on case complexity and competence of a trainee doctor.
- The surgical cover at nights was as follows: one SHO (senior house officer) covering general surgery, one registrar in general surgery, one SHO in trauma and orthopaedics, and one SHO covering ear, nose and throat. Medical care for surgical inpatients was also provided by the resident medical SHO and resident medical registrar when needed. Also, out of hours cover was provided by the non-residential middle grade doctor on call and non-resident consultant on call. Surgical staff did not always attend the Hospital at Night team meetings. We observed a Hospital at Night meeting where there was not a representative from the surgical services.
- We observed and staff told us the on-call doctors were also carrying out ward rounds and frequently had to leave half way through the round if for example they were called to a theatre. This was not an efficient use of staff time who had to wait for the doctor to return. In one case we saw staff waiting over 30 minutes for a consultant.

Surgery

- Rotas confirmed consultant group provided 24/7 on-call consultant cover with a different consultant covering from Monday to Thursday day time shift, and usually the same consultant providing a cover Friday to Sunday.
- At pre-operative stage some patients were referred for an anaesthetic review. We observed the service had a comprehensive 'referral to anaesthetist criteria' document.
- We observed a morning handover meeting which was well attended and started promptly at scheduled time. Staff discussed clinical cases and there was evidence of collaboration between surgical specialities. This was also an opportunity for consultants to teach junior doctors.

Major incident awareness and training

- We saw a documented major incident plan and evidence of major incident training.
- Emergency planning training was mandatory for all staff. Training completion rate for surgical services was 99% and met the trust's target of 90%.

Are surgery services effective?

Requires improvement



We rated effective as requires improvement because:

- We did not see evidence of how results of the national audits were used to drive local quality improvement programmes. We saw little evidence that local clinical audits were regularly carried out.
- With the exception of surgical safety checklist audits, we saw no evidence of discussions or learning from clinical audits that had been undertaken. Senior staff told us results of local audits were discussed at ward team meetings however we did not see evidence of this.
- Not all patients were screened for malnutrition as required by NICE guidelines.
- Patients were not given the opportunity to choose whether to eat/drink at or away from their bed. Most patients ate their meals in bed.
- The hip fracture audit in 2015 and the National Bowel Cancer Audit in 2014/15 showed the surgical service performed worse than the England average. The relative risk of readmission in urology was slightly higher for elective patients in comparison to the England average.

- Theatre utilisation was low, with most theatres below 50% utilisation. Staff told us theatre underutilisation was due to late starts, delays between cases and early finishes.
- Staff appraisal rates were variable with between 67% and 71% having had appraisals on three wards and two wards where all staff had had appraisals.
- Not all nursing staff who looked after patients requiring tracheostomy care has received relevant training. Most of the substantive nursing staff we spoke with were concerned about the agency staff competencies.
- Staff told us there were not enough ward clerks to deal with the administrative work which put extra pressure on nursing staff.
- Staff told us that in approximately 80% of cases staff did not know when doctors were coming to carry out patient rounds. Staff told us about difficult and negative working relationships with some doctors which did not promote good teamwork.
- At weekends resources were focused on the most unwell and emergency patients.
- Staff told us IT system was temperamental and frequently crashed while IT support was slow to resolve issues.

However:

- Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies and were available on the hospital's intranet.
- Pre-operative assessments for patients that we reviewed were comprehensive and covered all health and social care needs.
- Staff we spoke with demonstrated good understanding of evidence based care such as management of sepsis or pre-operative assessment
- Patients' pain was assessed and managed effectively.
- Nursing staff appropriately referred patients to a dietitian.
- Junior doctors across different surgical specialities were very complimentary about their training at Whipps Cross University Hospital.
- Daily MDT board rounds took place on wards with a nurse in charge, discharge nurse, social worker, physiotherapist and occupational therapist (OT). We observed good MDT working in operating theatres.

Surgery

- Staff from pre-operative assessment unit had an on-line access to GP records of patients from the local area.
- Staff we spoke with demonstrated good understanding of their responsibilities under MCA and DoLS.

Evidence-based care and treatment

- Clinical guidelines and policies were developed and reviewed in line with the National Institute for Health and Care Excellence (NICE), the Royal Colleges and other relevant bodies. Policies and protocols were easily available on the hospital's intranet. Also, some wards kept hard copies of protocols available for all staff in an office.
- Pre-operative assessments for patients that we reviewed were comprehensive and covered all health needs (clinical needs, mental health, physical health, and nutrition and hydration needs) and social care needs. Patient records we reviewed showed patients' care and treatment was planned and delivered in line with evidence-based guidelines.
- At the time of the inspection, the hospital participated in a number of national audits. These included audits of head and neck cancer, prostate cancer, major trauma, learning disability mortality review, elective surgery, emergency laparotomy and inflammatory bowel disease.
- We asked for evidence of how results of the national audits were used to drive local quality improvement programmes. The trust did not provide us with this information.
- The surgical service provided us with an auditing program for 2016/17 to monitor compliance with NICE guidance related to trauma injuries, general surgery, urology, ENT and gastroenterology. At the time of the inspection, the audits were ongoing and the data was not available. The trust did not provide us with an audit programme for the previous year.
- We reviewed a large sample of various meeting minutes such as clinical governance meetings, surgical division clinic leads, consultants' meeting and audit, ward meetings and saw no evidence of any discussions or learning from audits that had been undertaken. An exception was a theatre governance meeting where staff regularly discussed monthly surgical safety checklist audits. Some meeting minutes listed 'audit program', but no further information was available to indicate discussions or updates about audit results.
- Theatre staff told us surgical perioperative audits such as infection prevention, hygiene, scrub technique, catheter were recently introduced. The results were discussed at the monthly theatre governance meetings and we saw evidence of that.
- Nursing staff told us they carried out local audits such as nursing documentation, catheter, cannulation, medication and patient standards of care. Senior staff told us results of audits were discussed at ward team meetings however after reviewing meeting minutes we did not see evidence of that. Also, staff told due to staff shortages and time constraints the meetings did not always happen.
- Staff we spoke with demonstrated good understanding of evidence-based care such as management of sepsis or pre-operative assessment. We found these protocols were well defined and staff followed the relevant guidelines. We asked the trust for a sepsis audit, however we were not provided with the relevant information.
- Approximately one month before the inspection, the surgical service commenced an enhanced recovery programme to improve patient outcomes and speed up a patient's recovery after surgery. The aim of the programme was to focus on making sure patients were active participants in their own recovery process and to ensure they received evidence based care. The program was still in its early stages therefore no data was available to show the outcomes.

Pain relief

- Patients' pain was assessed and managed effectively. The hospital had a dedicated pain team who assisted with chronic and acute pain. They did daily ward rounds, and three times a week a consultant joined them. Out of hours pain was managed by an on-call anaesthetist.
- Pain medication was usually administered by oral or intravenous routes. There was limited use of epidural anaesthesia and patient-controlled analgesia (PCA) pumps (except for certain conditions) due to increasing use of enhanced recovery protocols. This was in line with best practice.
- Staff used proformas for pain assessments. There were specific pain charts used for PCA and epidurals. We saw

Surgery

treatment plans documented in patient records. We reviewed a sample of five prescription records which had analgesia proscribed and were appropriately administered.

- During nurse intentional roundings staff asked patients whether they were in pain. We saw this was documented in patients' records. Patient we spoke with told us their pain was managed well and they received analgesia in a timely manner.
- Hospital wide formal pain assessment audit completed in 2016 showed three out of five surgical wards were 100% compliant with recording a pain score. However, the audited sample was small and included approximately five patient records per ward.
- Staff told us pain control was reasonable based on reports on delays and omissions in administration. We requested to see the report but the trust did not provide us with this information.

Nutrition and hydration

- The Malnutrition Universal Screening Tool (MUST) was used to assess and record patient's nutrition and hydration. Monthly MUST audit data from five wards between October 2015 and March 2016 showed lack of compliance with MUST completion, with 20-84% completion rates against target of 95% and average score around 60%. This means not all patients were screened for malnutrition as required by NICE guidelines.
- We observed nursing staff appropriately referred patients to a dietitian during handovers in response to patients' unplanned weight loss.
- Staff told us where required, patients were given assistance with eating and drinking. Food served on a red tray indicated a patient required assistance with their meal. There was no consistent system on the wards to identify patients requiring assistance with their meals. Some wards wrote 'RT' or placed red tray picture on a board above patient's bed, other staff learned about it during a handover.
- Royal College of Nursing best practice states where clinically appropriate, patients should be given the opportunity to choose whether to eat/drink at or away from their bed. We saw that this was not the case, and majority of patients ate their meals in their bed. Out of

43 patients we observed during meal time 31 ate their lunch in bed. A staff member told us they did not always have the time to assist patients out of bed if they required assistance.

- We observed patients had access to drinks by their bedside within reach.
- On a board above patient's bed staff marked whether a patient was 'nil by mouth' or could drink and eat.

Patient outcomes

- The hip fracture audit in 2015 showed the surgical service performed worse than the England average for five of the six measures, which included patients being admitted to orthopaedic ward within 4 hours (3.7% against a national average of 46.1%). Also the overall average length of patient stay was 25.7 days compared with a national average of 20.3 days.
- Results from the National Bowel Cancer Audit in 2014/15 showed that case ascertainment rate was 70% compared to the England average of 94%. Data completeness for patients having major surgery was low and scored 58% compared to the England average of 80%.
- In the National Emergency Laparotomy Audit (NELA) 2015 Patient Report surgical service scored within the top percentage (100-80%) of questions for four measures such as case ascertainment, or arrival in timescale appropriate to urgency theatre. The service scored average percentage (79-50%) for four measures such as direct admission to critical care, preoperative review by consultant surgeon and anaesthetist, or CT reported before surgery. The service scored the lowest percentage (49-0%) for three measures such as consultant review within less than 12 hours of emergency admission, or risk documented preoperatively.
- At Whipps Cross University Hospital, the risk of readmission for both elective and non-elective surgery was similar or slightly lower to the England average between December 2014 and November 2015. However, risk of readmission in urology was slightly higher for elective patients. This meant following surgery patients were at a slightly higher risk of being readmitted than in other hospitals in England.
- The trust's Patient Reported Outcome Measures (PROMS) were generally in-line with national results.

Surgery

Overall, the trust's results were comparable with those seen nationally in PROMS measures for hips and knees replacement, which measure patients' outcomes of health following surgery. The groin hernia indicator was slightly worse than national average.

- Theatre utilisation was low, with most theatres below 50% utilisation between February and April 2016. Staff told us theatre underutilisation was due to late starts, delays between cases and early finishes.

Competent staff

- At the time of the inspection, appraisal completion rates varied between different surgical areas. For example, all staff from Sycamore and Poplar Ward had their appraisal, Rowan Ward had 68% of staff appraised (although we were told this improved after the inspection to 85%), Sage Ward had 71% whilst in theatres 67% of staff had been appraised.
- Competency-based training and further education programmes were available to staff. Most nursing staff we spoke with were happy with a range of courses and training available to them although some told us progression was slow. Nursing staff told us about completing cannulation, IV or taking blood competency courses. We reviewed a sample of nursing staff competencies which were reviewed in timely manner.
- We saw evidence that training and professional development was provided to nursing staff. Many nursing staff in the eye clinic were multi-skilled and able to assist in the the operating theatre and recovery. Seven recovery staff had completed critical care training. Nursing staff told us a mixture of patients on the wards made it good place for nurses to learn about providing care and treatment to a variety of patients.
- At the time of the inspection two surgical wards had three patients requiring tracheostomy care. A senior staff member told us they encouraged hospital to send this type of patients to their ward as this gave their staff sense of satisfaction and expertise. However, a staff member told us they received minimal training in relation to tracheostomy care. We were told some nurse were going to be sent for a training in the near future. We saw no evidence how many nurses were trained in tracheostomy care.
- A senior staff on a ward told us they wanted to introduce more nurse specialist training. The hospital already had nurse specialists in urology, colorectal, oncology, head and neck, pain, orthopaedic and ophthalmology.
- Most of the substantive nursing staff we spoke with were concerned about the agency staff competencies. They gave us a number of examples when agency staff refused to care for patients, were not competent in dealing with complex cases, refused to wash patients, did not escalate unwell patients, or took one hour to do a task that should take significantly less time.
- Agency nurse's skills and competency were discussed and checked during the induction on the first day of their shift. However, a staff member told us "I don't know [agency staff's] capabilities until I start working with them."
- Student nurses told us they found their placement beneficial, with one nurse describing her experience as "wonderful". They told us everybody was very helpful, they had learned a lot and would recommend Whipps Cross as a placement.
- Four nurses told us about taking responsibilities of a higher band without being promoted. A staff member told us this did not give them a sense of achievement.
- We saw a number of additional courses nursing staff attended in the past year such as pressure area care, time management, safeguarding, leadership, managing sepsis or end of life care. Staff told us they often booked additional training on their days they were not working and received time off for the extra hours worked.
- Overseas nurses were offered a preceptorship programme and, when required, language lessons.
- Two senior staff members told us there was a monthly surgical nurses forum dedicated to teaching and development. Nurses received a certificate they attended the forum which they could use for their revalidation. However, the number of nurses that could attend the forum depended on the staffing levels which often was challenging. Issues with staffing levels did not allowed managers to offer protected learning days for their staff. Past forum topics included pressure sores care, Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS), escalation of deteriorating patients and governance.
- Junior doctors across different surgical specialities were very complimentary about their training at Whipps Cross University Hospital. They told us they received "excellent training both theoretical and operating experience" and that they were "very well supported by

Surgery

consultants". Doctors described their placement as "truly excellent", "one of the best places in the UK to train" and that the hospital was 'place to go' in terms of teaching.

- Junior doctors received training in theatres and monthly or biweekly formal teaching. Majority of junior doctors told us their work was regularly assessed and they were allocated to cases suitable for their level of competence. They told us they discussed their cases with consultants and that the consultants attended high risk and complex surgeries. However, some doctors told us there were a lot of unsupervised registrar level lists.
- We observed good teaching during procedures from consultants to junior doctors, operating department practitioner (ODP), theatre practitioners and recovery nurses.

Multidisciplinary working

- Daily ward rounds were undertaken by medical and nursing staff. Rowan Ward, Poplar Ward and Primrose Ward had a high mixture of patients from different surgical specialities as well as medical care patients. A senior nurse told us it was challenging to attend all doctor's rounds. We were told that in approximately 80% of cases staff did not know when doctors were coming to review their patients which made their work more difficult.
- A senior staff told us there were limited opportunities for nursing staff to discuss and analyse clinical incidents with medical staff.
- Nursing staff in recovery, theatres and wards told us most doctors were approachable and they worked well together. We heard and saw a number of examples when nurses positively challenged doctors and discussed patient care. However, staff also told us some registrars and consultants "think we are just nurses and do not know what we are doing". Nurses told us there was a sense of hierarchy. A nurse told us about being undermined by a doctor in front of patients. Nursing staff said despite working with some doctors for years they always refer to them as 'nurse', they never said hello or acknowledged them, unless they needed something, and they often did not say 'thank you'.
- There was daily support on the wards from a ward clerk. However, staff told us there were not enough clerks to deal with the administrative work. Nursing staff told us this put additional pressure on them as they needed to

answer phones, enquiries and complete discharge paperwork when clerks were not available, for example nursing staff had to cover annual leave, sickness, after 5pm and weekends.

- Hospital at Night was a clinically driven and patient focused meeting, attended by multi-professional and multi-speciality staff to delivering care at night and out of hours. Although we found the meeting to be thorough and the team engaged, there was not a representative from surgical service to discuss surgical patients. We were informed surgical representatives often attended the Hospitals at Night meetings unless they were in an operating theatre. No contingency was in place to mitigate such circumstances despite Hospital at Night policy stating the attendance at the handover of surgery/urology staff was mandatory.
- Daily MDT board rounds took place on wards with a nurse in charge, discharge nurse, social worker, physiotherapist and occupational therapist (OT). However, at the time of the inspection OT team had a high level of vacancies and therefore they struggled with the workload.
- We reviewed notes of two patients with complex needs which evidenced regular MDT support. There was input from a dementia and delirium team, dietitian, OT and discharge coordinator. We saw that discharge plans were in place with key workers, social services and accommodation arranged.
- Embedded into acute assessment unit (AAU) was a clinical decision unit (CDU) run by A&E doctors and nurses. AAU staff told us they had good input from the CDU staff. AAU doctors and nurses had a daily meeting where they discussed patients. They also had input from a geriatrician who provided advice on caring for elderly patients.
- We observed good MDT working in operating theatres. Staff communicated effectively and there was good team work.
- Four junior doctors told us they felt MDT worked well in surgery and offered a good learning experience for them.
- Cross-site head and neck MDT held weekly meetings where the team discussed approximately 40 patients. The team comprises of ENT consultant surgeons, maxillofacial surgeons, oncologists, pathologists, radiologists, clinical nurse specialists, speech and language therapists, dietitians and restorative dentists.

Surgery

Seven-day services

- Service leaders told us surgical services were working towards seven-days working however this was not in place yet and the resources were focused on the most unwell patients.
- Nursing staff told us weekends were not very well staffed and most junior doctors came under a lot of pressure. We were told at weekends there was “a regular conflict with between caring for elective patients and caring for emergencies.”
- There were two emergency theatres operating 24/7. After 10pm they covered immediate life, limb or organ-saving intervention.
- Staff told us there was good out-of-hours (OOH) access to radiology, including weekends. Medical staff told us they could seek advice from a duty radiologist who was always available.
- Pharmacy dispensary service was available between 9am and 8pm. At weekends, pharmacy service operated between 10.30am and 2pm. Outside these hours an on-call Royal London Hospital pharmacist provided support.
- Staff told us therapy services, in particular physiotherapists, were freely available at weekends.

Access to information

- Staff from pre-operative assessment unit told us they did not have major issues with accessing patients' medical records. Staff also had an on-line access to GP records of patients from the local area which they told us was very beneficial.
- A number of staff on the wards expressed frustration at the ongoing difficulties they experienced with the IT system. They told us the system was temperamental and frequently crashed while IT support was slow to resolve issues. Staff told us at times they were unable to access patient's test results in a timely manner and instead had to telephone the relevant department which was not efficient way of working. Staff told us also said they did not have enough computer stations.
- Histopathology services were based at Royal London Hospital and staff told us receiving results was slow. They said at times they waited more than two weeks for a cancer diagnosis. This had also impact on multidisciplinary meetings and patient's first follow-up meeting in clinic.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information about Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) were displayed on the wards. All staff received a basic MCA and DoLS awareness training which was part of the adult safeguarding eLearning course. Staff we spoke with demonstrated good understanding of their responsibilities under MCA and DoLS.
- We observed consent process prior to a surgery, medical examination or tests. We saw consent was obtained from patients in line with the trust's policy. All of the patient records we checked had a completed consent form for any procedures, or surgeries. The forms contained details of the operation/procedure and any risks associated with this.
- If a patient did not have capacity to make a decision about their treatment, best interest meeting took place and a DoLS form was completed. Medical staff gave us examples of holding a best interest meeting for patient who lacked capacity.
- Patients living with dementia had their capacity assessed on admission. We reviewed two sets of notes belonging to patient's living with dementia. One indicated the patient had capacity therefore DoLS were not required. The second set indicated patient lacked capacity and DoLS application commenced. There was an input from the mental health team and dementia and delirium team. We saw relevant assessments and discussions (including with family) were documented.

Are surgery services caring?

Good



We rated caring as good because:

- Most patients we spoke with told us their experiences of care were positive.
- We observed a number of situations when staff protected patients' dignity and privacy.
- Most patients told us staff had caring attitude and were professional and respectful.
- The majority of patients told us they were kept informed about their care and were given enough information about their treatment.

Surgery

- We observed good and respectful communication between patients and staff.

However:

- Some patients who had surgical procedures walked (accompanied) in a dressing gown from theatres to a ward which they found to be undignified.
- Response rates for Friends and Family Test for most surgical wards were very low (between 11% and 16%).
- The percentage of patients that would recommend the hospital to family and friends was variable across the wards and fluctuated between months with scores between 71% and 100%.
- We observed not all nursing staff introduced themselves when approaching patients. We saw nurses discussed a patient's care and treatment as though the patient was not there.
- We were not made aware of any support available to patients and those close to them to help them cope emotionally with their care and treatment.

Compassionate care

- Most patients we spoke with told us their experiences of care were positive. In theatres, recovery areas and on wards we observed patients were mostly treated with respect and their dignity was maintained at most times. We observed a number of situations when staff had drawn curtains to protect patients' dignity and privacy, for example when doctors were examining patients, when a patient deteriorated and required urgent intervention, or when a nurses wanted to calm down a distressed patient.
- However, theatre staff told us some patients who had surgical procedures walked accompanied in a dressing gown from theatres to a ward which they found to be undignified. Staff told us patients who had certain procedures were asked if they were 'happy' to walk back from theatres.
- Most patients told us staff had caring attitude were professional and respectful. They commented that, "staff are brilliant and work so hard". Another patient said staff was good "just understaffed but they do their best". A patient told us nursing staff "always have time for me", another commented nurses were "as good as gold".
- Patients appeared clean and looked after. A patient who required assistance told us they were washed and changed every day. Patients told us, "hospital is

fabulous, "absolutely brilliant care", "patient care is brilliant, I can't fault [the nurses]", and they felt the received "very good care". One patient told us "service is much better than last month".

- Between April 2015 and March 2016 response rates for Friends and Family Test for most surgical wards were below the England average of 30%. Eye Treatment Centre, Plane Tree Centre, Poplar and Primrose achieved between 11% and 16% response rate.
- Percentage of patients that would recommend the hospital to family and friends was variable across the wards and fluctuated between months. For example, on Poplar Ward, scores was between 79% and 100%, on Primrose Ward results were between 71% and 100% and on Sage Ward results were between 83% and 100%. There was no upward or downward trend indicating improvement or deterioration.

Understanding and involvement of patients and those close to them

- Most patients told us they were kept informed about their care and were given enough information about their treatment. We observed that during medical ward rounds care and treatment plans were discussed with patients and they were given opportunity to ask questions. Patients told us they "felt involved in decision making", that they had "excellent experience" and that "everything was explained".
- Most patients told us staff introduced themselves and explained their roles. However, during two handovers we observed not all nursing staff introduced themselves when approaching patients. We also saw nurses discussed a patient's care and treatment as though the patient was not there.
- None of the patients had concerns regarding the way they were treated or had been spoken to.
- We observed good communication between patients and staff during their operation. With staff explaining the process and ensuring patients were aware of what was happening.

Emotional support

- A number of clinical nurse specialists supported ward-led care, including colorectal, palliative and oncology specialist nurses.
- We were not made aware of any support available to patients and those close to them to help them cope emotionally with their care and treatment.

Surgery

- There was a chaplaincy service available for patients' religious or spiritual needs.

Are surgery services responsive?

Inadequate



We rated responsive as inadequate because:

- We saw limited evidence of improvements being made since the last inspection in 2014 to plan the service in order to be more responsive and meet the needs of the patients.
- The trust suspended monthly mandatory 18-weeks Referral to Treatment (RTT) reporting from September 2014 due to significant data quality concerns.
- The percentage of patients whose operations were cancelled and not treated within 28 days was worse than the England average.
- Some theatre cancellations happened on the day of surgery due to overrunning of surgical lists. We were told some overruns were due to theatre lists starting late which was a common occurrence. We found the timing of theatre list and available supportive services such as radiology meant the theatres were almost destined to start late.
- The average length of stay in trauma and orthopaedics was longer than the England average for both elective and non-elective surgeries.
- Patients were not given an indicative date of discharge instead they were given an estimate number of days they were expected to stay in the hospital.
- Staff told us out of hours discharges occasionally happened due to the lack of available patient transport. Frequent delays in discharge happened due to patients waiting for their medication and blood test results.
- Patients on Rowan, Poplar and Sycamore Wards told us the wards were noisy and they found it difficult to sleep and have a good night's rest.
- Patients gave us mixed reviews about food. With some patients the choice of food could have been better.
- Despite having a very diverse local population we did not see leaflets available in any other language apart from English.
- We saw limited evidence that learning from complaints were identified and discussed.

However:

- Not long before the inspection surgical services introduced integrated discharge team which aimed to improve discharge process from hospital.
- Data provided by the trust there were no mixed-sex breaches on surgical wards.
- Most patients told us nursing staff responded promptly to call bells although the wards did not audit these.
- Wards had a direct access to nutrition and dietetic services.
- Staff we spoke with were knowledgeable about caring for patients living with dementia and staff had access to a dementia specialist nursing team.

Service planning and delivery to meet the needs of local people

- Leaders of the service told us they had large population of elderly patients and a large proportion of patients living with dementia. Dementia awareness training was mandatory for all staff and we saw good completion rates across the surgical services meeting the trust's 90% compliance target. The one exception was medical staff in orthopaedics and plastics where 87% of staff completed the training. We also saw the wards focused on falls prevention and pressure ulcers care. There was good input from dementia and delirium team.
- However, the hospital environment was not dementia friendly and did not support patient's independence. Also, nursing staff on the wards told us staffing levels did not always allow for one-to-one care where it was needed.
- The surgical wards did not reflect recommendations for delivery by the Royal College of Surgeons (RCS) with elective care not separated from non-elective care.

Access and flow

- The trust suspended monthly mandatory 18-weeks Referral to Treatment (RTT) reporting from September 2014 onwards. This followed the identification of significant data quality concerns relating to the accuracy, completeness and consistency of the RTT Patient Tracking List. Since this suspension, the trust has implemented a full RTT recovery programme. At the time of the inspection the RTT data was incomplete and therefore inaccurate.
- Although the trust was not reporting the RTT data to the national systems, they stated the surgical services had improved their RTT performance driven by the surgical leadership triumvirate through the weekly

Surgery

divisional planned care access meeting. Data submitted by the trust showed the incomplete performance for the surgical division had improved from 72-75% between May and July 2015 to 80-82% between May and July 2016.

- The percentage of patients between 2014/15 and 2015/16 whose operations were cancelled and not treated within 28 days was worse than the England average. During third quarter of 2014/15 around 30% of patients whose operations were cancelled were not treated within 28 days. This has improved to around 10% in quarter four of 2015/16 with the England average around 8%. The trust took an action in early 2016 to reduce the 28 day rebook failures. Data provided by the trust showed that between January and July 2016 there was one 28 day rebooking breach.
- Elective lists were planned approximately 10 days ahead with patients being added even a day before a surgery. We saw evidence staff attended daily theatre list finalisation meetings where they considered theatre utilisation and cancelled patients, sometimes a day before a surgery, if the list seemed overbooked.
- Between January and December 2015 there were 1,016 cancelled elective surgeries. The highest cancellation rate was in ophthalmology with 244 cancelled operations, followed by orthopaedics 177 and urology 166. We asked the trust for a number of repeated cancellations and reasons for cancellations but no data was provided.
- Staff in theatres told us some cancellations happen due to lack of intensive care unit (ICU) or high dependency unit (HDU) beds. Although, staff were unable to tell us how frequently this happened they said there were very few such incidents.
- Theatre staff told us sometimes cancellations happened on the day of surgery due to overrunning of surgical lists. We were told some overruns were due to theatre lists starting late which was a common occurrence. We found the way a theatre list was scheduled (the time the first patient was sent for, time of team brief and access to radiology) made it almost unavoidable that would start late.
- The trust told us they reduced a number of on the day patient initiated cancellations by employing an additional member of the admissions team who was contacting patients in advance of their operation. The trust stated this resulted in a reduction in the number of patients not attending their appointments although no data was provided.
- We asked the trust for a percentage of theatre lists which started late in the last six months. The trust provided a number rather than proportion which shows that between March and July 2016 there were 805 theatre lists that started late across 13 operating theatres.
- Staff in recovery told us there were issues with patient flow due to bed availability which caused them a significant amount of stress. Between May 2015 and April 2016 there were 129 patients who experienced an overnight stay in recovery. Of these, 52 patients were identified as needing HDU/ITU beds. None of the patients stayed more than one night and the trust told us they were transferred to a ward the day after their overnight stay. We found the recovery was not suitable for nursing patients for long periods as it did not offer privacy, toilets were not located nearby, the environment was noisy, there were issues with feeding patients and visitors were not allowed.
- The average length of stay at Whipps Cross University Hospital for most surgeries was in line with the England average for both elective and non-elective admissions. However, average length of stay in trauma and orthopaedics was longer than the England average for both elective (5.2 days against England average of 3.4 days) and non-elective (11.2 days against 8.7 days) surgeries.
- A pilot review of a length of stay conducted in June 2016 showed that of 101 patients on four surgical wards 41 were categorised as 'fit patients'. The main reason why patients were waiting for a discharge was that they were receiving a clinical treatment that could not be delivered in community. The main reason patients were deemed 'unfit' was because they were waiting for occupational therapy/physiotherapy's approval for discharge.
- Staff told us discharge planning commenced at the admission stage. We saw evidence of discharge planning in patient notes. However, patients were not given an indicative date of discharge rather an estimate number of days they were expected to stay. Most patients we spoke with did not know when they were

Surgery

going home. For example, one patient told us they had been told to expect two to five day stay, another told us they had no idea when they were going home and that they had been waiting for some time.

- Not long before the inspection surgical services introduced integrated discharge team that aimed to improve discharge process from hospital. The team consisted of discharge coordinators who took lead in patients' discharges, arranged resources such as transport, input from social services and pharmacy, and coordinated repatriation of patients to different hospitals.
- Staff told us out of hours discharges happened occasionally due to the lack of availability of patient transport. Frequent delays in discharge also happened due to patients waiting for their medication and blood test results.
- Surgical assessment unit was incorporated into the acute admissions unit (AAU). Staff told us surgical patients in AAU took longer to be seen by a doctor due to doctors being in theatres. At the time of our visit to the unit there was one surgical patient (out of 58). Staff told us majority of patients were medical but at times they had had up to 10 surgical patients.
- Poplar Ward was a short stay ward (approximately two to three days) with high turnover of patients, many discharges and admissions. However, staff told us they had long-staying patients who were on the ward for months, even a year.
- Ward bays usually had six to seven beds, and each bay had variety of patients from different specialities. For example, during our inspection Rowan Ward had patients receiving care and treatment for head and neck injury, urology, orthopaedics, bowel, abdominal pain, ENT. Additionally, the wards had a number of medical patients however staff told us there was a good medical team cover to support their care.
- Surgical wards were either single sex or had a separate wing for male and female patients. Data provided by the trust showed there were no mixed sex breaches reported on surgical wards.

Meeting people's individual needs

- Patients on Rowan, Poplar and Sycamore Wards told us the wards were noisy and they found it difficult to sleep and have a good night's rest. They told us too many lights were on during the night, some bins did not have a soft closure mechanism therefore made loads of noise

when closed, staff talked loudly and telephones were not turned down. Staff on the ward told us they provided patients with ear plugs and eye mask however some patients told us they were not offered these. Patients told us there was no routine on the wards and they did not know the time the staff turned the lights off at night.

- Patients gave us mixed reviews about food. With some patients saying the food was "alright", "satisfactory", "edible" to "awful" and "not liking the food". Some patients told us the choice of food could have been better. Most patients told us the food arrived warm.
- Most patients told us nursing staff responded promptly to call bells. We asked the trust for results of call bell audits however we were told these were not available. The trust told us a senior nursing team were designing a standard approach to call bell audits across the trust.
- Wards had a direct access to a nutrition and dietetic services. An onsite dietitian frequently reviewed patients and was easily contactable. Speech and language therapy service was available on referral.
- Staff told us they felt competent to care for patients with a learning disability. If needed they would ask a learning disability nurse for assistance however during our visit we did not see examples of care and treatment delivered to patients with a learning disability.
- Staff we spoke with were knowledgeable about caring for patients living with dementia and were able to explain each type of dementia. Patients were identified and assessed on admission to the hospital. Staff told us they assessed patient's needs on individual basis. When necessary patients received one-to-one care although this was not always possible due to staff shortages.
- Staff across surgical wards told us they had access to a dementia specialist nursing team. A dementia nurse daily visited the wards. We reviewed two patient records for patients living with dementia; all had appropriate care plans and evidence of input from the dementia team. We also saw two incidents where staff calmed down a confused and agitated patient. The interaction was positive with staff being calm, reassuring and supportive.
- The wards had restrictions on visiting times, although staff told us they used their discretion and allowed relatives to stay longer if it benefited patients. For example, if a patient was agitated or was living with dementia and needed to be calmed down.

Surgery

- The wards introduced protected mealtime when visitors were not allowed and patients could eat their meal without unnecessary interruptions.
- Despite having a very diverse local population who spoke 120 languages with a large representation of Pakistani, Polish and Romanian people we did not see leaflets available in any other language apart from English.
- If a staff member spoke the relevant language they would translate for and to patients (or their relatives). Staff told us a translation telephone service could be accessed for patients for whom English was not their first language. We observed an incident when medical staff struggling to communicate with a newly admitted patient who was unable to communicate in English. Despite this, no telephone interpretation was arranged therefore the patient could not fully engage in their consultation.
- Outside Hope Ward there was a poster explaining to the patients what to do when English was not their first language. This information was available in a variety of languages.

Learning from complaints and concerns

- Staff told us they always tried to resolve complains locally. If a patient or relative wanted to make a complaint they would speak to the nurse in charge. If the issue was not resolved satisfactorily patients were directed to the Patient Advice and Liaison Service (PALS). We saw example of staff apologising to a patient regarding a concern they had and providing them with PALS details.
- Between May 2015 and April 2016 there were 83 formal complaints attributed to different surgical wards and areas. Of these complaints, four were not responded within the timescale set by the trust.
- The largest number of complaints (22) were received by the ophthalmology department, followed by Rowan Ward (13) and Plane Tree Centre (12). Most common complaints related to diagnosis and treatment (37 complaints), communication (20 of which 11 related to staff attitude), and delays in care (14).
- Nursing staff told us a number of complaints from patients were about agency nurses. Patients complained about “poor care”, “uncaring practice”, and

“bad staff”. Since patients did not know whether a nurse was from an agency or a substantive member of the team, staff told us they felt this unfairly reflected on their work.

- A ward manager gave us example of how they worked with HR to address poor staff attitude which was the main theme of patients’ complaints. The manager told us the problem seemed to be resolved, but they continued to monitor the issue by reviewing complaints each month.
- Nursing staff on the wards told us they discussed patients’ complaints during monthly team meetings. However, we only saw evidence this was happening on Rowan Ward.
- Medical staff discussed complains during monthly clinical governance meeting. We reviewed two to three meeting minutes per each speciality and we saw evidence that complaints frequently featured on the agenda. However, it was not evident any learning points were identified.

Are surgery services well-led?

Inadequate



We rated well-led as inadequate because:

- Most staff we spoke with were not aware of the vision and plans for the surgical services. Most staff we spoke with were not able to tell us what the trust values were.
- Surgical and cancer clinical academic group (CAG) meetings did not appear to feed into the specific surgical speciality clinical governance or ward meetings.
- Specialist surgical clinical governance meetings (apart from theatres) were not well embedded, poorly attended and some were not represented by service leads. We found some meeting minutes to be brief therefore it was unclear what was discussed during the meetings.
- Ward and theatre risks were not all captured and escalated. Two risks were on the risk register for three years and one for four years.
- Although ward meetings were scheduled monthly, staff told us they were haphazard and did not always happen.
- A number of staff in different areas told us about ongoing issues of bullying and harassment despite

Surgery

senior staff members and leaders telling us this was no longer an issue. Nursing staff told us service leaders were not supportive and staff told us it was difficult to escalate concerns at board and trust level. Staff felt the trust was not supportive of whistle-blowers.

- A number of staff told us about being bullied and unfairly treated by a manager. Staff told us personal clashes with the manager prevented them from promotions, gaining access to training and development opportunities. Another staff member told us that since they could not prove instances of bullying or favouritism they would not be believed or listened to.
- Nursing staff who worked in different clinical areas (wards and theatres) told us about a blame culture within the service.
- While leaders of the service talked about a 'family like' atmosphere the opposite was said by most of nursing staff. Nursing staff said they did not feel valued, appreciated or recognised.
- We observed poor collaboration, communication and lack of understanding between AAU, recovery and wards with staff blaming each other for poor patient flow.
- A number of staff in different clinical areas we spoke with were visibly distressed by their experiences of working in the hospital and were tearful.
- We saw limited attempts by the surgical service to engage and consult patients. Most staff felt the service did not consult or update them about any plans.

However:

- We found nursing staff to be committed to the hospital and we found them to be dedicated, caring and motivated to deliver care and treatment to patients.
- A nursing representative from each hospital area attended a daily safety huddle to enhance patient safety across the hospital.
- There was ongoing work to implement the National Safety Standards for Invasive Procedures (NatSSIPs) and to develop the Local Safety Standards for Invasive Procedures (LocSSIPs).
- The service introduced a 'joint school' initiative for orthopaedic patients undergoing joint replacement surgery to improve their recovery after surgery.

Leadership of service

- The surgical service had a site based leadership team. A clinical director, associate director of nursing, and service manager, provided leadership of the service. This team provided the main point of leadership and management for patient-facing staff.
- Most senior staff members and leaders told us there were no issues with bullying and harassment. We were told that previous blame culture was no longer an issue. This was despite a number of staff in different areas telling us about ongoing issues of bullying and harassment which they had discussed with senior staff, managers and service leaders.
- Nursing staff told us service leaders were not supportive and they felt let down by the trust. Staff felt the trust's response to issues they raised was slow. A staff member told us it was difficult to escalate concerns at board and trust level. We were told about two examples when issues were escalated to the executive level with no action taken.
- Nursing staff told us about ongoing issues that were not addressed despite raising them with managers. As a consequence some staff were negative about reporting issues to senior managers and felt they would not be supported by the service leaders.
- Staff told us about a ward manager who was not approachable and "rude". Staff told us they decided to escalate the issue to a more senior manager. As a result the manager in question showed them a "cold attitude". Another staff member on a ward told us that since they could not prove instances of bullying or favouritism they would not be believed or listened to.
- Staff told us personal clashes with a manager prevented them from getting promotions, and from gaining access to training and development opportunities. They gave us three examples of when their manager treated some staff more favourably than them. One staff member told us "I just want to be treated equally".
- A nursing staff told us about being spoken to by their manager in "the way it is not acceptable", another staff member told us their manager shouted at them.
- We reviewed a sample of team meeting minutes which we found to be hostile, blaming and intimidating with phrases such as "zero tolerance", "not be tolerated", "this behaviour should stop now and will not be tolerated any longer" and a number of references to staff being performance managed with possible disciplinary action if something was not done.

Surgery

- We were told about allegations of significant bullying and intimidation in theatre and staff being fearful without support from service leaders. Staff also told us about a longstanding issues relating to a doctor allegedly reported for bullying and intimidation.
- Nursing staff who worked in different clinical areas (wards and theatres) told us about blame culture within the service. They described and showed us examples when managers and medical staff questioned their professional judgement, blamed and/or reprimanded them for incidents or raising them rather than focusing on solutions and lessons learned. This included staff raising concerns about patient safety. Staff told us they “felt powerless to do anything”.
- Nursing staff told us about a manager who “managed from their office rather than the ward” and rarely supported the team when they were struggling with the workload. Staff told us that when staff reported issues with the workload due to high level of agency nurses the manager told them to “coordinate better”.
- Senior staff told us they had introduced ‘thank you cards’ which they gave to staff to show appreciation and recognition. However, staff we spoke with told us they never heard about nor received a thank you card. Nursing staff said they did not feel valued, appreciated and recognised. A staff member said it was a “thankless job”.
- There seemed to be poor collaboration, communication and lack of understanding between AAU, recovery and wards with staff blaming each other for poor patient flow. For example, Staff on the wards complained about the recovery and AAU who were sending patients without a prior phone call, while staff in recovery and AAU said the wards never answer the phones. Staff on the wards felt that other units did not care about their pressures and staffing levels and sent them patients without notice or when they were not ready. On the other hand, staff in recovery and AAU said they had to move stable patients onto the wards to allow steady patients flow and issues with bed availability was causing them stress.
- However, we also visited surgical areas (ward, theatres and recovery) where staff was positive about their managers who they found very supportive and encouraging. They told us about a ward manager who was always thinking of patients and staff best interest and thought of new ideas on how to improve the service.

- We saw good example of leadership on Sage Ward where management told us about initiatives they took to improve culture and staff attitude. They managed to reduce vacancy rates and improved sickness absences.
- Many senior staff members told us service managers and leaders were accessible, visible and supportive. One senior nurse told us they “couldn’t get better manager” and that they offered “great ideas on how to build this team”. A senior staff member they told us the leaders were supportive and that their concerns were listened.

Vision and strategy for this service

- Staff told us they were reminded to revise the trust values before the inspection. Despite this most staff we asked were not able to tell us what the values were.
- Most staff we spoke with were not aware of the vision and plans for the service. Some staff told us about “a journey” and that the service still had a long way to go, but were not able to tell us any more details. A senior staff member told us service leaders had a vision and loads of plans and they would be told about them in the near future. Another staff member told us they overheard something about plans for the service but were not officially told about them.
- Senior surgical service managers and leaders told us the services had a clear vision and strategy. The trust recognised the existing configuration of the surgical wards was not fit for purpose due to clinical demand and patient needs which adversely affected patients experiences and flow. The surgical services had a vision to reconfigure the surgical wards making them fit for purpose, and reduce costs at the same time. The services had plans to make surgical wards into dedicated speciality led wards aimed to reduce length of stay and enhance the MDT care of patients. Also, at the time of the inspection the hospital was about to open two new operating theatres.
- The surgical triumvirate had produced a document outlining their expectations of how a perfect week in surgery should look like. The vision was to deliver improvements in patient care and flow.

Governance, risk management and quality measurement

- The clinical services across the hospital were organised into clinical academic groups (CAGs) aimed to promote clinical standards, best practice and shape longer-term plans for service transformation. We saw evidence

Surgery

surgical and cancer CAG discussed quality, operational and financial performance of the directorate. Following each CAG meeting staff identified actions and responsible lead. We saw evidence the actions were completed within timescales. However, it was unclear how information about the directorate's performance was passed to the frontline staff since monthly team meetings, apart from theatre staff governance meetings, were haphazard. The CAG meetings did not appear to feed into specific surgical speciality clinical governance or ward meetings.

- In addition to CAG meetings, each specialist surgical area had their own local governance arrangements. However, we found that surgical and urology clinical governance meetings were not well embedded and were poorly attended. A staff member felt the management wanted the meetings to take place for CQC's benefit. Of four urology governance team meetings that we reviewed, two did not happen due to poor staff turn out including management, clinical governance, ward, and infection control teams. One meeting that took place was of limited clinical governance value since service managers and clinical governance representative arrived late and no risk register was reviewed as the register "was not brought along".
- Clinical governance meetings across surgical specialities varied in quality and detail. There was no set agenda across the specialities with ophthalmology and theatres having the most detailed agendas that were focused on governance and quality of the service. ENT and surgical governance meetings were least detailed. We found the meeting minutes to be brief therefore it was unclear what was discussed. Meetings of the surgical clinical governance meeting from July 2016 noted the meetings were not attended by senior sisters therefore it was "difficult to get specifics of ward issues".
- Although ward meetings were scheduled monthly, staff told us they were haphazard and did not always happen. On one of the wards staff told us a meeting did not happen for the past two months due to time constraints and being understaffed.
- Despite the risk register being discussed during governance meetings we identified that ward and theatre risks were not all captured and escalated such as risks related to the high use of agency staff or issues with correctly capturing surgical site infections (SSIs). Twenty-one of 36 risks related to equipment and its

maintenance. Three risks were on the register since 2012 or 2013 and nine since 2014 such as use of post-operative recovery due to lack of inpatients beds, consultant intensivist cover or capital bid for ENT console in theatres.

- A nursing representative from each hospital area attended a daily safety huddle, a meeting which aimed to enhance patient safety across the hospital. Safety huddles focused frontline teams around discussions and updates on specific patient harms such as safeguarding, enhanced care, end of life, pressure ulcers, falls, discharges, patients of concern amongst others. Staff told us they found the safety huddles helpful as they learned about what was happening in other areas of the hospital. They said the meetings also served as a forum for staff to identify gaps and discuss solutions. Inspection team observed a safety huddle which we found to be well attended and useful.
- To mitigate the suspended referral to treatment (RTT) reporting and ensure the cancer target compliance the trust undertook a clinical expert review of their patient tracking list (PTL) position. This was undertaken to identify potential procedure or patient groups who pose higher risks of harm due to waiting times. Trust told us on a monthly basis patients underwent individual harm review to ensure they had suffered no harm as a consequence of their waiting times.
- The service was working together with the Royal London Hospital to implement the National Safety Standards for Invasive Procedures (NatSSIPs) and to develop the Local Safety Standards for Invasive Procedures (LocSSIPs). The NatSSIPs bring together national and local learning from the analysis of Never Events, Serious Incidents and near misses through a set of recommendations that help provide safer care for patients undergoing invasive procedures. We saw evidence that a multi-disciplinary approach has been developed, implementation has commenced and updates regarding the NatSSIPs were regular item of theatres governance meeting agenda. We saw there was a robust implementation plan led by one of the consultant anaesthetists, theatre matron and practice development nurse for theatres, supported by the triumvirate consisting of clinical director, associate director of nursing and general manager.

Culture within the service

Surgery

- While leaders of the service talked about a ‘family like’ feel and atmosphere this was not reflected in the opinions of the majority of nursing staff.
- Staff felt the trust was not supportive of whistle-blowers. A staff member told us about concerns they raised under a newly introduced anti-bullying policy and they did not feel the trust lived up to its standards while the issue continued. Another staff member told us they felt they could not escalate their concerns through whistleblowing process due to fear of repercussions and their manager finding out. The staff member was visibly stressed and anxious to talk to us.
- A number of staff in different clinical areas we spoke with were visibly distressed by their experiences of working in the hospital and tearful when discussing examples of intimidation. We were told that some staff went off sick or left the service due to stress this has caused.
- Staff gave us examples of escalating issues with their managers but they received a negative feedback and nothing was done.
- Nursing staff told us they did not want to report concerns they had about doctors as they had “a status” and they management would think “I am in wrong because I am a nurse.” A staff member gave us an example of challenging a doctor for leaving patient notes unlocked. In response the doctor singled the nurse out for criticism. The nurse told us they found the doctor intimidating and they feared if they responded to the doctor they would be reported for being rude.
- A nurse told us “doctors get treated differently” and this was “something we needed to accept”.
- A number of nursing staff we spoke with were planning to leave as they were not happy with the work environment and lack of progression. A staff member said the service “haemorrhaged experienced staff”.
- A staff member on a ward told us that with such a high number of temporary staff that there was no sense of teamwork.
- However, nursing staff were committed to the hospital and we found them to be dedicated, caring and motivated to deliver care and treatment to patients. Staff told us “I love my job”, “we are passionate about patient care”.
- Nursing staff on one ward were more positive about their work. They talked about feeling “part of the team”,

“effective communication”, feeling “valued”, and “enjoying the work and atmosphere”. They were keen to talk about the ward’s achievements and felt supported and encouraged by their managers.

- Staff told us and we saw meeting minutes that a ward manager was making effort to improve culture on the wards and instil positive team ethos.
- Most doctors we spoke with told us about the hospital being “great place to work”, “excellent training”, feeling part of the trust rather than just the department and that there was “good team work”.

Public engagement

- Senior staff told us they knew patients were “happier” as the number of complaints decreased.
- Service leaders told us they intended to consult patients regarding plans for the wards. However, we were told the plans were already finalised.
- In December 2015 the hospital carried out a consultation on discharge however the sample of patients was small (10 adult patients or their carer). Following the consultation, the hospital introduced an integrated discharge team. However, the issues with delayed discharge highlighted by the patients still existed during our visit.
- Between October and November 2015 the hospital carried out the national inpatient survey. Eight hundred patients were sent the survey and there was a response rate of 38%. The hospital stated that many issues highlighted by the survey were starting to be addressed. However, during our visit we saw that some issues such as choice of food, provision of emotional support or noise at night were still present and we saw no evidence these were being addressed.
- Patients’ views of surgical wards were also being sought through the NHS Friends and Family Test however the response rates between April 2015 and March 2016 were low (between 11% and 16%).

Staff engagement

- Some senior nursing staff told us they were aware of the plans to introduce a single speciality wards but they were not updated or consulted about the plans and did not have opportunity to share their concerns.
- Nursing staff we spoke with did not know what the plans for the wards were and told us they were not consulted.

Surgery







Some staff told us about hearsay plans and told us about their concerns which they did not have opportunity to share with the leaders and senior managers.

- A staff member told us the hospital was for many employees their local hospital. They told us they “came here to give ourselves to our jobs” but they felt let down by the service leaders’ lack of support and not being informed of changes.

Innovation, improvement and sustainability

- The trust was awarded three National Quality in Care (QIC) Oncology awards for 2016 which included the “National Digital Innovation in the Treatment of Cancer” award. The digital solution to improve cancer team working is thought to be likely to be embedded within the UK Cancer Plan. One of Whipps Cross clinical nurse specialist achieved the "Oncology Nurse of the Year" award.
- The service introduced a ‘joint school’ venture for orthopaedic patients undergoing joint replacement surgery which enables the patient to make the best recovery possible after surgery. This was a two-hour class where health professionals prepared the patient with essential information regarding their procedure and recovery period. This was an opportunity for patients to discuss the process with nursing staff, physiotherapists, occupational therapists and member of the pain team. Patients also had an opportunity to talk to a patient who had previously undergone this surgery about what to expect.
- To improve communication with nursing staff some managers used a mobile messaging application as they found this was more effective than emails.

Critical care

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

Information about the service

An Intensive Care Unit (ICU) is a specially staffed and equipped, separate and self-contained area of a hospital dedicated to the management and monitoring of patients with life threatening conditions. The ICU provides both specialist and general critical care support for the local population. The unit had 645 admissions in the financial year 2015/2016 and observed an increase of 7.8% when compared with the previous year. The ICU had seven level 3 (intensive care) beds and two level 2 high dependency unit (HDU) beds, and there were plans to open a new HDU in September 2016 with a further eight beds. Patients who required level 3 care (advanced respiratory support alone or basic respiratory support with support of two other organ systems) could be admitted to an intensive care bed where they received one-to-one nursing care. Those patients too ill to be cared for on a general ward and requiring higher levels of care (more detailed observation/ intervention for a single failing organ system or require post-operative care) could be admitted to a level 2 bed where two- to-one nursing care was provided. If the capacity of the unit was exceeded, the ICU used the theatre recovery area as part of their escalation policy.

There was no designated critical care outreach team and the function of the outreach team was performed by the acute response team (ART). The team, led by a nurse consultant, provided support to ICU patients who were moved to medical or surgical wards, and assisted in the management of seriously ill patients on wards across the hospital.

We visited all areas of critical care over the course of the announced inspection; we accompanied the acute response team on the ward and attended handover meetings and hospital at night meetings.

During our inspection, we spoke with 27 members of staff including doctors, nurses and allied health professionals and ancillary staff. We also spoke with the directorate leadership team, four patients and their relatives. We checked 21 patient records and many pieces of equipment.

Critical care

Summary of findings

We rated this service as requires improvement because:

- Staff did not always record actions taken or learning points for incidents. The knowledge of incidents and awareness of shared learning was inconsistent. Learning points from mortality and morbidity meetings were not consistently followed up.
- Staff did not always have access to reliable equipment.
- There was no consultant intensivist cover for critically ill children. Consultant daytime working pattern was not consistent with the FICM recommendations for continuity of care.
- Intensive Care National Audit and Research Centre (ICNARC) data for April 2015 to December 2015 suggested the unit had higher than expected mortality levels (compared to similar units nationally). Senior staff were not fully aware of the latest ICNARC clinical audit data results.
- There was no agreed protocol for weaning and rehabilitation of long-term ventilated patients.
- There was limited evidence of relevant audit activity and where audits were carried out learning was not always shared with staff.
- The unit was failing to comply with a number of the 'London quality standards' for adult critical care. Not all patients were seen and reviewed by the consultant in clinical charge of the unit at least twice a day, seven days a week.
- Only 81% of patients were reviewed within 12 hours of admission to the unit.
- Due to lack of bed capacity, the unit was not meeting several professional standards for patient care as required by The Core Standards for Intensive Care Units (FICM, 2013). Patients were waiting more than four hours to be admitted to the unit and they were sometimes cared for outside the ICU by staff without intensive care training.
- Bed occupancy levels for the ICU, reported to NHS England by the trust were consistently higher than the national average.

- Bed pressures meant that patients were sometimes transferred out of the unit for non-clinical reasons and many patients were transferred out overnight contrary to professional standards.
- There were mixed-sex accommodation breaches on the unit owing to the lack of capacity, which service leads had not highlighted as a risk.
- There were no designated facilities for relatives to stay overnight.
- There was no documented long-term strategy for the division and staff had poor awareness of the leadership's plans for the department.
- The acute response team (ART) was not able to provide a 24-hour, seven-day service and plans to provide this cover did not seem sustainable. There was poor oversight of the acute response team as it was not managed within the department and division. The team's activity was not monitored to ensure the team responded to all referrals promptly.
- The risk register did not fully document all risks identified across the unit and senior divisional leaders had limited awareness of key challenges, risks, and serious incidents which occurred on the critical care unit.

However:

- All staff we spoke with demonstrated a good awareness of policies and how to access them. They had a good understanding of their responsibilities with regards to safeguarding patients from harm or abuse.
- There was a positive culture on the unit, staff were friendly and open and felt confident raising concerns. They were positive about local leadership on the unit.
- Staff worked to meet individual needs, for example through translation services, communication tools, and individualised patient diaries, which were used to record patient's likes and dislikes as well as religious and spiritual beliefs.
- Observations of care showed staff maintained patient privacy and dignity. All observed interactions between staff working at ICU and patients were positive. Feedback from patients and relatives was generally very good and they felt they were treated with courtesy, respect and compassion by staff.

Critical care

- Patients were provided with psychological and emotional support and had an opportunity to discuss their time on the unit with the consultants and nursing staff that had cared for them.
- Relatives told us the staff were helpful and gave them regular updates and that they felt suitably involved in their loved one's care.

Are critical care services safe?

Requires improvement



We rated safe as requires improvement because:

- Although levels of incident reporting had increased, staff did not always record actions taken or learning points for some of these incidents. Staff knowledge of incidents and awareness of shared learning was inconsistent.
- Actions recorded in mortality and morbidity meeting minutes did not have documented completion timescales or shared learning points and were not consistently followed up at future meetings.
- Sanitising hand gels were not easily accessible by staff at the patient's bedside and the location of hand gels and sinks meant that staff did not routinely clean or sanitise hands after touching the patient environment. Although the unit reported 100% compliance in hand hygiene audits we observed some medical staff did not use hand gels at all when approaching patient or moving from one patient to another. We observed non-clinical staff and external personnel enter the unit without following infection control measures and they did so unchallenged by the nursing or medical staff.
- Staff did not always have access to reliable equipment. The unit's AGB machine regularly broke down meaning staff had to leave the unit to process samples and there was a risk of delay. Although this was recorded as a risk on the unit's risk register, measures to minimise the impact on patient safety were not documented.
- There was no consultant intensivist cover for critically ill children. There was a risk of patient harm due to reliance on the ICU consultant to provide care for care for critically ill children whilst they wait for transfer to a paediatric intensive care unit. Consultant daytime working pattern was not consistent with the FICM recommendations for continuity of care.

However:

- Staff had a good understanding of their responsibilities with regards to safeguarding patients from harm or abuse.
- Medicines were managed appropriately in line with relevant guidelines.

Critical care

- Nursing staffing allocation was consistent with the national guidance on staffing within the critical care setting.

Incidents

- The critical care unit reported no 'never events' in the previous 12 months. There was a never event action plan in place for Whipps Cross Hospital, which was reviewed regularly. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- The unit reported a misplaced nasogastric tube incident in May 2015. The investigation into the incident took over three months and was undertaken by the associate director of nursing surgery and cancer, consultant in critical care and governance manager. The report noted that staff were open and honest when assisting with the investigation process and quick responsive actions were taken once incident was noted. An action plan was developed with outcome measures identified and date for compliance noted. Critical care governance group was responsible for overseeing implementation of it.
- Staff reported incidents through an electronic incident reporting system that was accessible by all staff. There was 188 critical care related incidents, logged through the hospital electronic incidents reporting system, between May 2015 and April 2016. Records indicated an increase in incidents reporting with the critical care unit reporting 178 incidents for December 2015 to July 2016. Incidents were categorised as, in highest occurrence order, delays in care provision, communication issues, pressure ulcers, medicine and continence management. We saw there were no actions taken, or learning points noted on some of these incidents. In one case, the x-ray department did not respond to the bleep from a staff on four occasions when they were required to confirm the Naso-Gastric (NG) tube placement of a patient. Lack of response caused the delay of the patients feed. In another case, the arterial blood gas machine was not working. This caused a delay in getting the blood gas result as the sample was sent to the laboratory where only one biochemist was working.
- Staff awareness of incidents was inconsistent and not all staff we spoke to could recall most recent incidents and

actions taken in response to them. Matron said incidents were discussed at the monthly staff 'debriefs', learning from incidents was noted on the staffroom noticeboard.

- Records for April 2015 to March 2016 showed there were 97 deaths within critical care. The ICU held monthly mortality and morbidity (M&M) meetings to review deaths on the unit. These were combined with the senior staff meeting.
- We reviewed five sets of mortality and morbidity meeting minutes. The minutes reviewed covered a period from November 2015 to April 2016. We saw that matters arising from previous M&M meetings were usually discussed, however, in three cases "no issues raised from the minutes of last M&M" was noted in the minutes, despite actions being recorded in previous months. All actions were allocated to a named consultant, however, there was no completion timescales or shared learning points identified. For example in March 2016, it was noted that a patient death should be discussed with the lead for end of life care for the hospital. In April 2016, no reference to this action point was recorded, so it was not clear if it was completed. In the November 2015 minutes, an action from a previous M&M meeting to obtain inquest reports was recorded. However, in later months' meeting minutes there was no record of this action being completed.

Safety thermometer

- The ICU participated in the NHS Safety Thermometer scheme. The NHS safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence.
- MRSA and C.diff are both healthcare-associated infections (HCIs) that can develop as a direct result of healthcare interventions such as medical or surgical treatment, or from being in contact with a healthcare setting. The hospital audited MRSA screening in critical care. Data for October 2015 to March 2016 showed 70% to 100% compliance with screening requirement. There was one case of MRSA colonisation reported in critical care in April 2016. However, no incidents of MRSA

Critical care

bacteraemias occurred in critical care for the period of April 2015 to March 2016. The root cause analysis carried out by the hospital showed the MRSA case was avoidable.

- One case of C.diff was reported in critical care in December 2015 and actions were put in place to prevent future occurrence.
- The critical care unit also reported three, hospital acquired, grade 3 pressure ulcers in November 2015. The root cause analysis was undertaken by the senior member of the team to analyse factors contributing to the incident. Staff reported good access to tissue viability nurse.
- The unit's quality dashboard, which included some safety thermometer data, did not include data related to patient falls or catheter urinary tract infections (C.UTI). Data available to us via Health and Social Care Information Centre showed no falls recorded in ICU between April 2015 and April 2016. There were only two C.UTIs recorded which were in August 2015 and April 2016.

Cleanliness and infection control

- Staff asked relatives to wash their hands on entering the unit. Relatives told us they were pleased staff made them do this as it gave them reassurance infection control measures were taken seriously by staff. However, we saw that hand gels were not easily available to staff around bed spaces as sinks and hand gels were positioned behind patients' beds. We observed some medical staff did not use hand gels at all when approaching patient or moving from one patient to another. In some cases they were prompted by nurses. We observed that not all doctors washed and sanitised their hands when entering the unit. It was not a routine procedure to clean or sanitise hands after touching the patient environment. The infection control audit for April 2015 to June 2016 showed 100% achievement for critical care in hand hygiene, infection rates and ward cleanliness.
- The audit also checked for staff compliance with insertion and care procedures for central venous catheters, urinary catheters, and ventilators tubing changes and suctioning practices to prevent ventilator-associated pneumonia. The monthly audit results for 2015/2016 demonstrated 100% compliance with procedures.
- Nurses and healthcare assistants completed infection control training levels 1, 2 and 3 (97.4%). The trust did not provide data related to doctors training in infection control.
- There was a dedicated member of staff responsible for cleaning the unit's general ward areas. Bed spaces and medical equipment were cleaned by the nurses and healthcare assistants assigned to each patient.
- There was easy access to personal protective equipment (PPE) in all areas we inspected and staff used PPE during their activities as required. Staff were 'bare below the elbow' in line with infection prevention and control guidelines.
- We saw that disposable curtains around bed spaces were clean and that they were labelled and dated to indicate when they were last changed.
- Equipment such as commodes and various measuring equipment by patients side were clean. However, there was dust on other equipment such as computers, printers and in non-clinical areas of the unit.
- Intensive Care National Audit and Research Centre (ICNARC) data showed the rate of unit acquired blood infections was better than the average and other similar units.
- There were three infection prevention and control link nurses responsible for linking with the hospital lead and for overseeing the overall standards.
- There was one side room which could be used for isolating patients who were at risk of transmitting, or more prone to catching an infection from others. The room was not used for that purpose at the time of the inspection but staff told us if it was, they would need to wear suitable PPE prior to entering it and ensure the doors remained closed and had appropriate warning sign on it.
- There was a storage room at the back of the ICU. People who wanted to access the room needed to walk through the entire unit to do so. During our inspection, we saw a delivery man was allowed to enter the clinical area with a delivery trolley without following the unit's infection control measures. We also saw two workmen entered the unit without following any infection control measures. Staff told us it was a regular practice that the room was accessed by non-clinical staff. None of the ICU team have challenged the practice or asked these people to adhere to infection prevention and control measures, such as hands washing, or sanitising.

Critical care

Equipment and environment

- There was an electronic swipe card entry system for staff and a buzzer entry system at the entrance of the unit for visitors. This meant staff could control who accessed the unit when the door was secured.
- There was a reception desk, staffed during the day, where relatives were welcomed and could ask questions. Most of staff working at ICU (97%) completed security training.
- The trust carried out a 'six-facet' survey in 2013, which included the Whipps Cross Hospital's ICU. This survey is required by the NHS Estate Code, it is focused on physical condition, statutory compliance, space utilisation, functional suitability, environmental management and quality audit. There was a plan to repeat the survey in 2016/17 in order to use it to inform the estate strategy and to support the site redevelopment strategy. The trust recognised that the facilities fell short of the standards required by the health building notice (HBN) due to their age, condition and layout and that a major site redevelopment was required. The critical care facilities were not fully compliant with the current HBN requirements. The ICU was constructed before the current HBN was published.
- Sharps containers were available at each bed space and within the medication preparation area. These containers were correctly labelled and not over filled.
- Equipment was tested to indicate it was safe to use. The hospital kept service records and staff knew how to report broken equipment should there be a need.
- Consumables required for day-to-day use were easily available to staff. They were stored in open containers on the unit; we saw that consumables were in date.
- The resuscitation trollies were appropriately equipped and checked by staff to ensure they were ready to be used in case of emergency. These checks were recorded.
- Staff told us they had no access to a glidescope (video-laryngoscope commonly used in the intubation of patients with difficult airways). We saw that it was recorded on the risk register since March 2015 and was discussed frequently at the senior staff meetings. There was a risk that avoidable patient harm could occur because of unavailability but we found there were no actions noted on the risk register to minimise this risk. It was not clear if the hospital was looking to purchase the device in near future.

- Staff also said the arterial blood gas machine used at the unit frequently broke down. It was recorded on the department's risk register that it was broken at least once every 24 hours. As a result staff had to leave the department to process samples. It took them away from patient care; they were also unable to process blood samples as quickly as they needed to. The risk register noted that there was a risk of delays to treatment and diagnosis and potential patient deterioration. There was no actions noted which would minimise that risk. Matron told us the hospital was looking to purchase another device to replace it but it was not clear how soon it would happen.
- Although most of patients were provided with 1:1 care or had a nurse or a healthcare assistant within their eye-line, not all had call buzzers within their reach as the beds were positioned in the middle of the bay to ensure access from all sides. Nurse did not routinely monitor if patient had access to the buzzer.

Medicines

- All medicines, including intravenous fluids, were securely stored behind keypad door.
- Staff monitored medicines storage temperature, it was within a safe range and checks were recorded.
- Controlled drugs were managed appropriately in line with relevant guidelines. Controlled drugs audits were undertaken by a pharmacist, stock was checked daily. Where staff used only a part of an ampoule it was recorded and the remaining content was discarded appropriately in presence of another member of staff. However, the controlled drugs audit undertaken in April 2016 noted that frequently (84 times) there was some missing information in records i.e. drug name, form, or strength. Occasionally entries were put in the wrong column (eight times) or balance was calculated wrongly (16 cases). The audit also found that drugs and the register were stored correctly, and daily balance checks were undertaken and any discrepancies investigated immediately.
- There was a designated ICU pharmacist present every day on the unit. When a temporary pharmacist covered the unit they were upskilled at another hospital in the trust. The ICU met the requirement of the Faculty of Intensive Care Medicine Core for 0.1 whole time equivalent (WTE) specialist clinical pharmacists for each single level 3 bed and for every two level 2 beds.

Critical care

- Prescription charts were fully completed and any allergies were documented in patients' records. The hospital undertook quarterly safe and secure medication audit, however, ICU was not included in the full audit.
- Medication stock items were ordered by the ward nurses using the stock list which was then sent to pharmacy. Required drugs were sent back to ICU on the same day via the pharmacy porter. Pharmacists told us they prioritised ICU medication requests.

Records

- Nurses and healthcare assistants completed training in clinical documentation (97%) to ensure records quality was appropriate to support clinical decision making. All staff, including administrative and clerical support staff completed information governance training (98%).
- In May 2016, the hospital carried out audit of completion of ICU discharge summaries for patients discharged in January 2016 and May 2016 to reflect two cohorts of medical and nursing staff (46 ICU patients). The audit indicated that 100% of patients' records assessed had a discharge summary; however, only one was fully completed. There was information missing in both medical documentation, including medical handover page, and nursing documentation. The audit recommended improvements in nursing rehab and input/output documentation, documentation of microbiology issues, photocopied paperwork, as it did not fully reflect completed paperwork. It also noted that documents were frequently incorrectly filed.
- All nursing charts were audited daily by the audit team and data was submitted to ICNARC after validation.
- Naso-gastric tubes documentation was reviewed in February and April 2016. Areas of concerns were discussed with ICU staff during staff handover and de-briefing meetings.

Safeguarding

- Trust training covered the competencies associated with the staff group for each role using the 'Bournemouth competence framework' for safeguarding adults. The trust recommended all staff receive face-to-face training on safeguarding adults and domestic violence as part of their induction. Face-to-face training was developed for all staff groups and provided on a regular basis with updates at a minimum of every three years.

- Records indicated that all but one staff (98%) completed safeguarding training level 1 for adults and children. Both trainings were routinely provided to doctors, nurses, healthcare assistants, and administrative and clerical staff. 95% of staff also completed level 2 children safeguarding training.
- Staff working at ICU had a very good understanding of safeguarding procedures, staff of all levels were able to provide us with examples when protocols would be initiated and knew who to contact should they require additional support.

Mandatory training

- All staff were required to complete mandatory training in health and safety, manual handling, fire safety awareness, infection control, information governance, basic life support, medicines management, medical gas safety, nutritional care, privacy and dignity, conflict resolution, security, blood transfusion, clinical documentation, complaints, and equality and diversity. Most of the courses were completed every two years with others every three years and some once only.
- The trust set a target of 90% for mandatory and statutory training completion. Records indicated that various staff groups working within the service achieved compliance at above 95% for all, but one of the mandatory and two of the statutory trainings.
- There was a low adult's basic life support training compliance rate, among additional clinical services staff (67%). There was also low compliance with moving and handling training (62.5%) and fire safety training (78%) among additional clinical services staff.
- The hospital reported that 100% of nursing and midwifery staff, administrative staff, and clinical support staff completed; fraud awareness, emergency planning, privacy and dignity, conflict resolution, equality and diversity infection control level 1 and 2 and information governance training.

Assessing and responding to patient risk

- An early warning system was used by staff to monitor patients across the hospital, promoting early detection and intervention if a patient's condition deteriorated and triggered the requirement of support from medical and nursing staff.
- The acute response team (ART) was responsible for reviewing all ICU step down patients (patients that are well enough to be moved on to a ward). The trust told

Critical care

us the ART team would receive routinely direct referrals for patients whose early warning scores were high. However, we spoke with nursing staff on medical and surgical wards who told us they would not routinely escalate to ART team but to a junior doctor or consultant responsible for care of the patient. Escalation to ART team was not included in the escalation protocol used by the hospital. Staff working on medical wards told us the team supported only step down patients and those who required continuous positive airway pressure (CPAP). Matron on one of the wards told us they were occasionally unable to reach the ART team due to gaps in mid-week cover. There was also no single point of contact for the team and staff were required to contact individual team members.

- The ART team had 4.6 whole time equivalent (WTE) senior nurse practitioners in posts with a 5.2 WTE allocation. The service aimed to provide 24 hours support but with their current staffing, were unable to provide this cover seven days a week. At least two weekday shifts (7.30am to 8pm) were not covered by the service. The hospital was looking to employ an additional nurse by the end of 2016.
- The service covered all adult wards and departments excluding maternity, emergency department and acute assessment unit. Nurses working within the team could make direct referrals to ICU if they deemed it necessary.
- All staff working for the ART team had acute care experience and one had qualification in critical care. They were able to act as a 'first responders' and undertook additional training in; recognition and response to deteriorating patient, patients requiring respiratory support therapy, assessment and management of a patient with a tracheostomy, altered airway, transfer of critically ill patients, direct arterial puncture, venepuncture and cannulation, urinary catheterisation and use of patient group directions.
- The matron told us that all delayed discharges over four hours and out-of-hours discharges (between 10pm and 7am) were reported weekly by the unit's audit team.
- 20, out of 52, members of staff working within ICU completed risk assessment training, and 97% of all nursing staff and healthcare assistants completed training in early warning systems.
- There was no consultant intensivist cover for critically ill children. There was a risk of patient harm due to reliance on the ICU consultant to provide care for care for critically ill children whilst they wait for transfer to a

paediatric intensive care unit. As noted on the risk register it could be for two to eight hours and leaved the ICU consultant unable to provide support to the unit and rest of the hospital.

- ICU staff and the acute response team knew how to safely transfer critically ill patient out of hospital or within the hospital. They attended a meeting where safe practice was reviewed to minimise any potential complications during transfers.
- The trust told us blood cultures or cultures of other specimens were undertaken for any patient with sepsis before starting antibiotics. The trust operated a rapid identification system once a bacteria or fungi was found in a clinical sample, informed staff of the name of the pathogen within a few minutes. The ICU implemented 'sepsis six care bundle' designed to reduce the mortality of patients with sepsis but it was a recent development therefore they had not yet audited compliance with the tool.

Nursing staffing

- Nursing staffing allocation was consistent with the Faculty of Intensive Care Medicine recommendations for continuity of care (FICM; Core Standards for Intensive Care Units). Level 3 patients were provided a minimum of 1:1 direct care by a registered nurse. Registered nurse to patient ratio of a minimum 1:2 to deliver direct care was maintained for level 2 patients. The unit had an identified lead nurse who was formally recognised with overall responsibility for the nursing elements of the service. There was also an additional supernumerary clinical coordinator on duty as recommended by the FICM.
- The vacancy rate recorded for the ICU in 2015/2016 was 25% with a turnover rate of 22% this was higher than the hospital average of 11.3% and 11.8% respectively. ICU was also looking to recruit 26 WTE for the new HDU unit due to open in September 2016.
- Sickness rate for nursing staff (1.7%) was lower than the hospital average (4.3%).
- Records indicated the use of nursing agency staff from April 2015 to March 2016 varied from 7.3% to 14.4%, with the average 11.2% of shifts being allocated to agency staff. It was lower than the hospital average of 19.6% and within the limit suggested by the best practice guidance which suggests that no more than 20% agency usage per shift.

Critical care

- 13.1 % of shifts were allocated to bank staff regularly working in critical care in April 2016. It was higher compared to previous months, for example there was 7.5% of shifts allocated to bank staff in November 2015 and on average it was 9.9% (November 2015 – April 2016).

Medical staffing

- There were nine consultants in posts. The consultant duty started at 8am and ended at 6pm on weekdays. The same consultant was on-call for that night. The 'on-call' shift was split into four hours of 'predictable on-call' and four hours of 'unpredictable on-call'. Records indicated that no locum doctors worked at the unit.
- During weekends, consultants started work at 8.30am to 12pm and then completed nine hours as unpredictable on-call to see any other new admissions.
- Other doctors were either CT2 trainees (core trainee years 2) from anaesthetic training program or ST3 trainees (speciality trainee year 3) from Bart's London School of Anaesthesia or middle grade anaesthetists from the anaesthetic department.
- Consultant daytime working pattern was not consistent with the FICM recommendations for continuity of care. The FICM recommended five day blocks of day shifts on to reduce burn-out in intensivists and maintain the same patient outcomes.

Major incidents awareness

- The hospital's major incident plan recommended minimum staffing levels for the ICU in case of major incidents. It also clearly listed responsibility of the ICU commander (ICU consultant or ICU registrar if out of hours) and of ICU nurse in charge. It also prescribed when to increase the ICU capacity by creating a satellite unit in recovery with the capacity to manage six ventilated patients. There was also additional business continuity plan to ensure that ICU could continue to provide services in case of disruption or interruption
- Records indicated that 98% of ICU staff attended emergency planning training.
- The matron and senior nurses were aware of business continuity plans. However, junior nurses (band 6 and 5) were unaware of what action to take should there be a major incident. We noted that band 6 nurses were in charge at night therefore should be fully aware of the protocol to facilitate team response.

Are critical care services effective?

Requires improvement



We rated effective as requires improvement because:

- ICNARC data for April 2015 to December 2015 suggested the unit had higher than expected mortality levels (compared to similar units nationally). Senior leaders told us they were not aware of this and we saw no plans to investigate or address the issue.
- There was no agreed protocol for weaning and rehabilitation of long-term ventilated patients. Use of standardised weaning protocols have been shown to produce better outcomes for patients.
- There was limited evidence of relevant audit activity and where audits were carried out learning was not always shared with staff. Staff we spoke with had poor awareness of clinical audits carried out by the unit.
- The unit was still failing to comply with a number of the 'London quality standards' for adult critical care. The standards, developed by NHS England London, represent the minimum quality of care that patients should expect to receive in every acute hospital in London. For example, this meant that not all patients were seen and reviewed by the consultant in clinical charge of the unit at least twice a day, seven days a week.
- The acute response team (ART) was not able to provide a 24-hour, seven-day service and plans to provide this cover did not seem sustainable.
- All patients should be reviewed in person by a consultant in intensive care medicine within 12 hours of admission to the unit. A recent audit indicated that only 81% of patients were reviewed within the set timescale.

However:

- All staff we spoke with demonstrated a good awareness of policies and how to access them.
- There was a tracheostomy working group which had developed a tracheostomy discharge pathway as well as a training programme and promoted good practice across the trust to ensure consistency of care.

Evidence based care and treatment

Critical care

- All staff we spoke with demonstrated a good awareness of policies and how to access them. They said they did not come across any problems with accessibility to key documents to support clinical decision making.
- There was no agreed protocol for weaning and rehabilitation of long-term ventilated patients. The frequency of daily breathing trials, where support from invasive ventilation was gradually reduced, was unclear. The unit did not use weaning timetables to record targets and parameters. There is evidence of reduced duration of mechanical ventilation, weaning duration and length of stay with use of standardised weaning protocols.
- The trust said the unit was compliant with the Intensive Care Society document Levels of Critical Care for Adult Patients (2009) which recommended allocating levels of care to patients according to their clinical needs and disregarded location or the prevailing nurse to patient ratio.
- Although some of the audit outcomes were discussed at senior staff meeting and clinical divisional meetings, sharing of the learning was not effective. We spoke with nurses and junior doctors and noted that they had poor awareness of clinical audits carried out by the unit.
- The department said they fulfilled the requirements of the rehabilitation after critical illness in adults' guidelines (NICE). However, they did not audit full compliance with the requirements of it.
- There was a tracheostomy working group which met monthly. The group was tasked with ensuring that best practice was followed when caring for patients who required the procedure. The group developed a tracheostomy discharge pathway as well as a training programme and promoted good documentation across the trust to ensure consistency of care. The consultant nurse leading the acute response team took lead for the hospital and delivered tracheostomy training.
- The trust completed self-assessment for the care received by patients who underwent a tracheostomy to ensure they met recommendations from the 'On the Right Trach?' a report by the National Confidential Enquiry into Patient Outcome and Death. The assessments suggested that the ICU was compliant with most recommendations. A critical care delivery group was responsible for ensuring compliance in areas where improvements were required. For example, in relation to night time critical care discharges, or reporting of unplanned tube changes as incidents.
- In 2013, the hospital undertook self-assessment to check on compliance with 'London quality standards' for adult critical care. The standards, developed by NHS England London, represent the minimum quality of care that patients should expect to receive in every acute hospital in London. The unit failed to meet four of 26 critical care weekday standards and nine of 26 weekend standards.
- Although there were mitigating actions, at the time of inspection the unit still failed to comply with several key standards. Not all patients were seen and reviewed by the consultant in clinical charge of the unit at least twice a day, seven days a week, with nursing and junior medical staff. The unit also did not meet the requirements related to daily review by microbiologists and pharmacists; a minimum of 70% of nursing staff to have post-graduate qualification in intensive care; a daily review by the MDT of the patient's physical and non-physical short and medium-term rehabilitation goals; prior to discharge all patients to be monitored with the 'national early warning score' for at least eight hours.
- All patients who died in ICU were reviewed and discussed at the monthly morbidity and mortality meetings. All patients were considered as potential organ donors. However, ICNARC data suggested that the hospital had no organ donation in 2015/2016. The trust told us from January to June 2016 out of the 47 patients who died in the ICU 11 of them were referred by staff to the transplant coordinator. Patients referred to the organ donation team were seen by the team at the unit and assessed for possible donation. Solid organ donation rate for the hospital was 0% for both donation following brainstem death (DBD) and donation following cardiac death (DCD). It was much lower than expected for DBD with similar units reporting 54% and lower than expected for DCD with similar units reporting donations at 1.2%.
- Staff used numerous care bundles that included a ventilator care bundle, central venous catheter bundle and urinary care bundle. They audited compliance on elements of the bundle to ensure staff followed the best practice.
- The hospital used Richmond Agitation and Sedation Scale (RASS) to assess patients' level of sedation, the tool is mostly used for mechanically ventilated patients.

Critical care

The unit carried out spot check audits and we were told these showed full compliance, however, they have not completed a formal audit to ensure patients were not over or under-sedated.

Nutrition and hydration

- We saw an example of a menu available to patients, it included vegetarian and gluten free options as well as mashable and pureed food items suitable for patients requiring a soft diet.
- Patient's medical records indicated fluid nutritional intake, charts were summarised and correctly calculated.
- Patients were offered food when able to eat and we observed they had free access to drinks, including fresh water available next to their bed.
- There was 0.6 WTE dietician provision for the critical care unit. The service was provided by two dietitians who responded to referrals from the ICU team. They attended the critical care unit each weekday morning to screen and assess all patients. The team received 0.6 WTE allocation for the new HDU beds.

Pain relief

- The unit introduced two tablet devices which were being trialled by level 2 patients to help improve communication between patients and staff. They included a number of communication tools for use by patients who were unable to speak. These included a pain-scoring tool which allowed patients to identify the location and level of their pain.
- We saw that patients' pain assessments were carried out by staff correctly and patients told us they had access to pain control medication when required.

Patient outcomes

- All patients discharged from the ICU had access to an ICU follow-up clinic. These run since August 2015 and included all patients who were on the ICU for 72 hours or more. Patients were invited to a clinic after 2 or 3 months of being discharged from the unit. The hospital was in the process of auditing the follow-up clinics to identify the learning and trends from the 12 months August 2015 to July 2016. The anonymised feedback from these sessions was shared with staff via a monthly summary on the staff noticeboard.

- We reviewed cardiac arrests audit and found no concerns specific to ICU. Majority of the data was at trust-level and although it indicated the trust had a higher than average number of cardiac arrests it was not above average for the critical care division.
- Core Standards for Intensive Care Units was developed by the Faculty of Intensive Care Medicine which recommends that patients should be reviewed in person by a consultant in intensive care medicine within 12 hours of admission. The hospital completed an audit of consultant reviews 12 hours post admission (January to June 2016), the audit indicated that only 81% of patients were reviewed within the set timescale.
- Intensive Care National Audit and Research Centre (ICNARC) data for April 2015 to December 2015 suggested the unit had higher than expected mortality levels. Risk-adjusted acute hospital mortality recorded rate was 1.27 (expected to be 1), it was high in particular in first quarter of 2015/2016 (1.38). Risk-adjusted acute hospital mortality predicted risk of less than 20% figure was recorded at 1.17 (expected to be 1). It was unusually high in the first quarter of 2015/ 2016 (1.85). Senior leaders were not aware of any problems and abnormalities and there were no plans to investigate or to address the issue.
- The data provided to ICNARC showed that, when compared to similar units, rates for patients readmitted to the unit within 48 hours (1.4%) were in line with the average for similar units.
- The ICNARC quality indicator dashboard also indicated that the hospital performed in line with expectations in relation to high risk sepsis admissions, out-of-hours discharges to the ward (not delayed), and non-clinical transfers. They performed slightly better than expected in relation to proportion of delayed discharges (over eight hours delays), and unit acquired infections in blood.
- ICU department contributed to the local critical care network which enabled further outcome and quality benchmarking, specifically against other local critical care units. The clinical lead participated in the clinical peer review pilot and the unit was expecting to undergo the review in 2016/ 2017.

Competent staff

Critical care

- The unit met the requirement of a minimum of 50% of registered nursing staff to be in possession of a post registration award in Critical Care nursing with 23 out of 40 nurses who achieved this award.
- Nursing staff undertook a role-specific programme in addition to attending the corporate induction programme. The education academy administration team was responsible for managing and administering all aspects of this programme. The hospital required temporary staff to complete all aspects of local induction prior to working at the hospital. Temporary workers in post for three months or more attended the corporate induction programme and completed the department's local induction.
- The junior medical staff were required to undertake a role specific induction programme. The medical education administrators were responsible for managing and administering all aspects of the junior medical staff programme.
- Management reviewed staff competency after six months in post and as part of the annual appraisal process. All staff were appraised annually.
- There was a practice educator allocated to the team, staff said they provided good support and felt they could develop skills required to perform their job effectively.
- Staff completed numerous competency assessments and the practice educator and matron kept log of it, to ensure they were competent to use equipment such as infusion pumps, ventilators, dialysis units, or suction pumps.

Multidisciplinary working

- There were monthly senior staff meetings attended by intensivist consultants, matron and deputy matron, psychology support practitioner, nurse consultant, organ transplant coordinator, palliative care consultant, physiotherapist, practice development nurse and senior staff nurse. During these meetings, attendees discussed audit data, any untoward incidents, staffing issues, and practice development.
- There were three physiotherapists, one occupational therapist and one rehabilitation support worker who supported the critical care team and surgical and medical wards. Their remit included attending to all acute respiratory patients, including critical care

patients as a high priority, first day post-operative patients and patients with mobility difficulties. They also supported as priority any patient whose discharge could be brought forward with therapy intervention.

- Critical care team was supported by two (band 7 and band 6) speech and language therapists, managed by a clinical lead (band 8a). They attended the 'trachea ward rounds' and were members of the tracheostomy working group. The majority of ICU patients referred to the team were seen daily. There was a plan to increase the establishment within the team (by 2 WTE) to support increase in HDU beds capacity with an opening of a new unit.
- Nurses and doctors said the working relationship with the speech and language therapists and physiotherapists were effective and they were all very involved with the unit. The ward round had daily input from nursing, microbiology, pharmacy and physiotherapy.
- Specialist ICU pharmacist visited the ICU every weekdays morning. There was a dedicated ICU bleep for any ICU related queries and support.
- The unit had three link nurses for infection prevention and control and access to tissue viability nurse. Staff said they found them very supportive. There were no link nurses for learning disability or dementia.

Seven-day services

- A member of the acute response team, which provided support to ICU patients stepping down to regular wards, was available during nights, weekends, and bank holidays. However, there were usually two weekdays when they operated only limited number of hours. In addition there was no cover arranged should one of the team was on leave.
- There was a consultant on call to the service out of hours able to attend within 30 minutes. Consultants worked on rotation and were responsible for ensuring the unit had adequate clinical cover from junior doctors at all times.
- Family liaison practitioner was available on the unit between 8am and 4.30pm Monday to Friday. Relatives could contact them in person or via email.
- There was a physiotherapy service available during weekends but no occupational therapy service because of low staffing levels. The trust told us the service should resume in by October 2016 if recruitment was successful.

Critical care

- Speech and language team at Whipps Cross Hospital provided 8.30am to 5.00 pm service Monday to Friday. Similarly, dietetics services were only provided 8.30am to 5.00 pm Monday to Friday.
- On site hospital pharmacist provided five days a week support, they were also available on Saturdays and Sundays 10am to 2pm, it was mostly over the phone support but they also visited the unit if requested. During out of hours there was access to the on call pharmacist via a bleep (weekdays 5pm to 9am and weekends 2pm to 10am). The critical care pharmacists were available to be contacted by the on call pharmacist to support any specialist queries.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- ICU unit developed a capacity and consent protocol to ICU admission and care which recommended when to treat patients in line with the Mental Capacity Act (MCA) and when patient met criteria for Deprivation of Liberty Safeguards (DoLS) to be put in place. The protocol was driven by the principle that patients were deemed to have capacity to make their own healthcare decision even if decisions made seemed unwise and could result in risk or harm. Staff worked closely with the hospital safeguarding team when considering DoLS.
- Staff received DoLS training from the safeguarding leads for the trust and there was an allocated link nurse for DoLS. They also received face-to-face training on the subject of MCA. Staff we spoke to had good awareness of issues related to both MCA and DoLS.
- The confusion assessment method-scoring tool for delirium management on the ICU formed part of the ICU observation chart. Staff also used a capacity assessment flow chart to establish if patient's capacity was in question and told us it was an "effective and useful tool".

Are critical care services caring?

Good



We rated caring as good because:

- All observed interactions between staff working at ICU and patients were positive. Feedback from patients and relatives was generally very good and they felt they were treated with courtesy, respect and compassion by staff.

- Relatives told us the staff were helpful and gave them regular updates and that they felt suitably involved in their loved one's care.
- Observations of care showed staff maintained patient privacy and dignity.
- We saw that where patient diaries had been completed by staff they had been written with kindness and compassion. Patient feedback praised the diaries.
- The unit had a dedicated psychological support practitioner who provide emotional support to both patients and those close to them.

Compassionate care

- All observed interactions between staff working at ICU and patients were positive. Staff were friendly, they explained what they did and answered patients and relatives queries, they ensured patients privacy and dignity were maintained.
- Nurses and healthcare assistants completed privacy and dignity training.
- The unit undertook a family satisfaction survey in June 2016. Questionnaires were available in the relatives' room. Thirteen relatives responded to the survey which asked them to feedback on process of decision-making, quality and availability of information and communication, quality of care and staff. Twelve relatives stated that the care provided at the unit was excellent or very good with one rating it as good and that both patients and relatives needs were considered by staff and they demonstrated courtesy, respect and compassion.
- Patients and relatives felt symptoms were managed well. Relatives comments included; "we felt very welcomed by all the staff and the atmosphere in general wasn't too scary for visitors", "friendly atmosphere, helpful nurses and staff", "the staff were fantastic". Others said; "the ICU can become very noisy", "staff always were busy with patients", and that it "would be good if they [staff] could turn off individual lights above each bed."
- The ICU used the NHS friends and family test designed by the NHS England to gather feedback from patients. This is a single question survey asking patients whether they would recommend the department to their friends and family. We have reviewed data available for May and

Critical care

June 2016, all response suggested that patients were likely or extremely likely to recommend the unit; however, the response rate was very low with 18 participants in total for both months.

Understanding and involvement of patients and those close to them

- We spoke with two relatives who told us staff were good at keeping them up-to-date and they felt well informed of their loved one's progress. One comment provided via the relatives survey stated; "I was impressed by the amount of staff and their knowledge and willingness to give information", another patient said staff were "very good at updating whenever we called". However, other comments included "staff unable to speak about injury to patient while on ICU, always had to refer me to senior person" and that "sometimes a foreigner [staff member] does not know English (...) but mostly the staff members spoke to my relative in English".
- Visiting hours on the unit were 4pm-8pm. Staff and relatives told us that these could be flexed to meet the needs of the patients and those close to them. We saw that staff were flexible in their approach and relatives of a newly admitted patient were able to visit their loved one in the morning. One relative commented, "If visitors are waiting for a long time we really do need a television to calm our nerves".
- Nurses told us relatives did not tend to stay overnight however they have had cases where relatives have stayed with a patient in a side room. Relatives said staff offered cups of tea, but they found difficult to get something to eat at night and had to leave the hospital site.
- Every patient who was on the unit for over 72 hours was given a patient diary. The diary was written for a patient during their time of sedation and ventilation, by relatives, nurses and others. The patient could read their diary afterwards to understand what had happened. The diary included a patient information page usually completed by relatives and included patients likes and dislikes and religious and spiritual beliefs. The diary contained a 'daily routine' page and a glossary of medical terms, both designed to aide patient and family member's understanding.

Emotional support

- There was a psychological support practitioner (PSP) who worked with the ICU team, they provided

psychological and emotional support to patients and those close to them. They also worked closely with the unit's practice educator to provide training and support to staff. For example, they ran a study day for all new ICU staff. It included training on end of life care, bereavement, holding difficult conversations as well as meeting the religious beliefs and needs of patients and those close to them.

- The PSP also worked as a family liaison practitioner and relatives were encouraged to get in touch with them should they have any queries or required support. Information how to contact them was provided by staff and available in the relative's room.
- The PSP also attended the consultants' morning handovers and was present during all difficult conversations with patients and family members. They also attended the monthly nursing "debrief" session.
- Staff told us they had a good working relationship with the chaplaincy team and that there was an all-faiths chaplain available 24hrs a day, seven days a week. There was also a poster in the relative's room which provided information on the weekly chapel services available for different faiths, including Catholic and Muslim services.
- The family satisfaction survey indicated that that access to emotional support was good, very good or excellent. We noted that the number of respondents was low (13 people participating).
- We saw example of where staff had written in patient diaries with kindness and compassion. There were example shared with colleagues as training aides in how to complete the diaries and deal with difficult topics.
- Sympathy cards were sent to every family of a patient that has died in ICU. It included information on attending a 'bereavement clinic', and how to access further support if required. The bereavement clinic was conducted with a consultant that looked after the patient and the psychological support practitioner.

Are critical care services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Due to lack of bed capacity, the unit was not meeting several professional standards for patient care as

Critical care

required by The Core Standards for Intensive Care Units (FICM, 2013). This meant that some patients were waiting more than four hours to be admitted to the unit and that patients requiring critical care were sometimes cared for outside the ICU by staff without intensive care training. A trust audit of delayed admission to ICU showed that between 1 April 2016 and 26 July 2016, seven patients waited more than four hours to be admitted to ICU from A&E. The trust told us that between May 2015 and April 2016 there were 52 patients that stayed overnight in the theatre recovery area that were identified as needing a HDU or ICU bed.

- Bed occupancy levels for the ICU, reported to NHS England by the trust were consistently at 100% or over (and consistently higher than the national average). The local team was unaware of the high occupancy level reported to NHS England. The data collected locally was not tallying with it and showed approximate occupancy levels of 90% in 2016; local managers were not able to explain the discrepancy in figures. Staff hoped that opening of the new high dependency unit (HDU) planned to open in September 2016 would help to lower the rate.
- There were mixed-sex accommodation breaches on the unit owing to the lack of capacity, which service leads had not highlighted as a risk. The unit reported 31 mixed-sex accommodation breaches between June 2015 and June 2016. The hospital set a timescale for reporting mixed-sex breaches which was contradicting professional guidance.
- Bed pressures meant that patients were sometimes transferred out of the unit for non-clinical reasons and many patients were transferred out overnight contrary to professional standards.
- The acute response team (ART) was not yet able to provide a 24-hour, seven-day service and plans to provide this cover did not seem sustainable.
- There were no designated facilities for relatives to stay overnight. This meant that relatives of very critical or unstable patients, or those who were not local and had travelled a long distance to reach the hospital, had to make their own accommodation arrangements.

However:

- Staff worked to meet individual needs, for example through translation services, communication tools and individualised patient diaries which were used to record patient's likes and dislikes as well as religious and spiritual beliefs.
- All patients discharged from the ICU had access to an ICU follow-up clinic. Patients were provided with psychological and emotional support and had an opportunity to discuss their time on the unit with the consultants and nursing staff that had cared for them.

Service planning and delivery to meet the needs of local people

- Whipps Cross University Hospital's Intensive Care Unit (ICU) took part in the North East North Central London Critical Care Network. The network was formed of lead health care professionals from 15 local critical care units with the aim of providing consistently safe, effective and coordinated care for patients. A recent network report demonstrated that the clinical lead for the ICU had been actively involved in a pilot of a peer review process with the aim of benchmarking quality standards and sharing best practice.
- Between 1 July 2015 and 30 June 2016, the ICU admitted 639 patients in total of which 521 were unscheduled admissions. As the majority of admissions to the unit was non-elective this affected service planning.
- Bed occupancy rates on the unit were consistently higher than the England average between June 2015 and May 2016. At the time of our inspection there were just two level 2 beds (along with seven level 3 beds) on unit which meant that patients requiring level 2 care were sometimes nursed on the wards or within the recovery area. Between May 2015 and April 2016, there were 52 patients that stayed overnight in recovery that were identified by a consultant as needing a critical care bed. To meet demand the trust were in the process of building a new High Dependency Unit (HDU) with eight level 2 beds. We were told by the service leadership team that they planned to open the HDU in September 2016 however at the time of our inspection there had not yet been successful in recruiting any of the 32 whole time equivalent (WTE) nursing staff needed. The associate director of nursing for planned care told us that nursing recruitment was recognised as a concern and we saw the potential delay to the HDU opening was recorded on the ICU risk register.

Critical care

- To provide a consistent and timely response to acutely unwell patients outside of the ICU the division's service managers were working to expand the acute response team (ART). There were plans to provide 24-hour outreach cover seven days a week from October 2016. Although the team planned to expand to 5.2 WTE band 7 nurse practitioners, during our inspection there were only 4.6 WTE which left at least two weekday shifts (7.30am to 8pm) without a dedicated ART service. It was also not clear how a sustainable 24-hour/seven-day service would be provided with just 5.2 WTE. The divisional leads told us they planned to set up a critical care working group in October 2016 to review the divisional structure and bring the ART into the same service division as the ICU which would improve oversight. However, it was not clear if the team's capacity to provide a 24-hour, seven-day service had been fully risk-assessed.
- The service ran follow-up clinics for all patients who had been discharged after being on the unit for 72 hours or more. The follow-up clinics were run by the unit's psychological support practitioner who provided psychological and emotional support to patients and those close to them. Patients were invited to attend a follow-up clinic between two to three months after discharge. Six full day sessions were available each month and patients had a choice about which session they attended. We saw examples of where the feedback from these clinics was shared with staff via a summary on the staff noticeboard. We were told by the psychological support practitioner that there was currently an audit of the follow-up clinics being carried out by one of the unit's consultants looking at the learning and trends from the 12 months August 2015 to July 2016.
- Although there was a dedicated relatives' room on the unit there were no separate facilities for relatives to stay overnight. This meant that relatives of very critical or unstable patients or those who were not local and had travelled a long distance to reach the hospital had to make their own accommodation arrangements. One relative we spoke with told us that he had been allowed to stay with his mother when she was admitted in the afternoon until around 2am but that he had been unable to stay overnight as he had been very tired and staff had offered him anywhere to sleep. Visiting hours were generally 4pm to 8pm however, staff told us they were flexible around visiting hours to allow relatives to

stay with patients at night if it was appropriate. We were also told that occasionally relatives had been allowed to stay in a side-room with a patient. There was a lack of any facilities for relatives to make their own drinks or access food out of hours. Staff told us they could offer hot drinks, water and biscuits but did not have the facilities to provide meals for relatives. Relatives we spoke with were satisfied with the visiting policy and told us staff had accommodated their needs

Meeting people's individual needs

- The unit reported 31 mixed-sex accommodation breaches between June 2015 and June 2016. A mixed-sex accommodation breach occurs in a critical care unit when there are male and female patients in the same unit and one or more of them no longer needs that level of critical care and becomes ready to be transferred to a level one unit, but there is no available bed for transfer. The trust told us that mixed-sex breaches were only reported by the ICU if, after 24hrs from when a bed on a ward had been requested, the patient was still on the unit. NHS England states that "it is not acceptable to set a time limit before recording a breach as the breach occurs the moment the patient is placed in the mixed-sex accommodation". Once the patient no longer needs that level of critical care, they become an unjustified breach and should be recorded both locally and nationally. We saw that staff attempted to maintain the privacy and dignity of patients who were ready for transfer to the ward by closing the curtains around their bed. The unit had not recorded mixed sex breaches as a risk on their risk register and had therefore had not documented any actions taken to reduce the impact on patients.
- A translation service was available 24-hours a day for patients whose first language was not English. The service was available via telephone and face-to-face if appropriate. We were given examples by staff of when they had used these services to have discussions with relatives. Staff told us that it was sometimes difficult to get access to the service quickly and so they often used staff on the unit who spoke other languages to help communicate with patients and their families. We saw patient information leaflets in the relatives' room were available in other languages from the patient advice and liaison service (PALS).
- Individualised patient diaries were used to record patient's likes and dislikes as well as religious and

Critical care

spiritual beliefs. Every patient who was on the unit 72 hours after admission was given a patient diary. The diary included a patient information page usually completed by relatives and included their loved one's likes and dislikes. It also included each patient's 'admission story' completed by his or her assigned nurse. This documented what had happened between the patient's arrival on the ward and when their diary was started. We also saw that the diary contained a 'daily routine' page and a glossary of medical terms, both designed to help patient and family members' understanding. We saw examples of the patient diary in use at the patient's bedside and saw diary extracts which were used as learning aides for staff. Former patient's attending follow-up sessions had provided positive feedback on how useful patient diaries had been in helping to fill in gaps in their memories. Feedback from relatives had led to the unit introducing blank 'takeaway sheets' that could be taken home for completion by family members and brought back to the unit to be added to the patient's diary.

- Communication tools were used by staff to assess individual needs where patients were unable to speak (for example if they had a tracheostomy tube). The unit had recently introduced two iPads which were being trialled by level 2 patients to help improve communication between patients and staff. These included a pain-scoring tool which allowed patients to identify the location and severity of any pain they experienced. There was also a free text option and a yes/no application. The unit's psychological support practitioner was working closely with the speech and language team (SALT) to identify which tools were most effective. Feedback from staff and previous patients was also being encouraged.
- We saw useful information for relatives and carers on noticeboards within the relatives' room. This included contact details for the family liaison practitioner (available 8am to 4.30pm, Monday to Friday) as well contact details for a charity supporting families and patients and for the hospital chaplaincy team. There were information leaflets available on numerous topics including organ donation, delirium, safe staffing levels, duty of candour and hospital acquired infections. We also saw copies of an 'Intensive care guide for patients and relatives' which contained useful information about the critical care environment. There were blank copies of the patient diary 'takeaway pages' for the family to

record important events that their loved one may have missed. There were also various feedback forms including the 'Did you get great Care today?' feedback form and post box to return completed forms and copies of the unit's 'Family satisfaction survey'.

- The unit's psychological support practitioner who told us that all bereaved relatives were invited to a follow-up clinic within one month. A consultant was also present at these sessions allowing relatives an opportunity to ask any questions about their loved one's care. These sessions provided emotional and psychological support to relatives through discussion of coping strategies and referrals to dedicated support networks. We saw that the unit's psychological support practitioner had adapted the trust's standard bereavement information pack to make it more relevant to the ICU. This included a specific list of support services available by location. This was as a response to feedback from bereaved relatives who had said that the support services were not always appropriate or accessible to them. Bereaved relatives were also offered a copy of the patient's diary to take away with them on the day the patient passed away, again this was introduced in response to feedback (relatives often did not want to return to the unit after their loved one's death.)
- Staff told us that the trust had individualised 'passports' for patients with learning difficulties but said that the unit did not regularly have patients with additional needs.
- Staff told us that there was no dedicated dementia champion or link nurse on the unit but that all staff had completed training on dementia awareness.
- We were told by the unit matron that if they had patient requiring a bariatric bed this could be made available within four hours. During our inspection we saw a bed delivered within this timescale and were told by staff they had access to a specialist hoist to safely transfer the patient.
- Patients who were transferred out of the unit to ward were provided with a follow-up session with unit's psychological support practitioner usually within a week of being transferred. This was to provide psychological and emotional support to the patient and help them adjust to the transfer.
- We saw an example of a menu available to patients who able to eat food by mouth. Various options were

Critical care

available including vegetarian and gluten free choices. Foods that were mashable and pureed food items suitable for patients requiring a soft diet were clearly marked on the menu.

Access and flow

- The ICU had a clear admissions policy and admission to critical care was usually agreed between the ICU consultant and the treating consultant. Admissions could only take place with the ICU consultant being made aware and referrals could only be made by the consultant responsible for the patient's care with the exception of patients referred from A&E.
- Bed occupancy rates on the unit were consistently higher than the England average between June 2015 and May 2016. There were 645 admissions to the ICU between April 2015 and March 2016, an 8% increase on the previous year. To meet demand a new High Dependency Unit (HDU) with eight level 2 beds was planned to be open from September 2016 however, this looked likely to be delayed.
- The unit had a clear escalation policy and in event of there being no suitably staffed, available beds within the ICU. Patients were cared for either in the A&E resuscitation room (for new patients) or in the recovery area of theatres 3 & 4 (for existing hospital patients). The trust told us that between May 2015 and April 2016 there were 52 patients that stayed overnight in the theatre recovery area that were identified as needing a HDU or ICU bed. We were told none of the patients stayed more than one night and they were transferred to ward beds on the day after their overnight stay. A trust audit delayed admission to ICU showed that between 1 April 2016 and 26 July 2016, seven patients waited more than four hours to be admitted to ICU from A&E. The Core Standards for Intensive Care Units (produced by the Faculty of Intensive Care Medicine [FICM] in 2013) states that admission should occur within four hours of making the decision to admit to intensive care. Therefore, the unit was not consistently meeting this standard.
- Due to high bed occupancy on the unit patients requiring intensive care were occasionally nursed in the theatre recovery area. The trust told us that between July 2015 and June 2016 there were 68 patients cared for in recovery for more than 4 hours. Staff nurses in the recovery area told us that they did not feel they had the level of skills required to look after patients requiring critical care although they said it did not happen very often and there was always an anaesthetist present. These concerns were also reflected in meeting minutes of the ICU monthly team de-brief (November 2015).
- Between July 2015 and June 2016 there were 20 occasions when elective surgical procedures were cancelled due lack of beds on the ICU. This is an improvement on our finding during our last inspection when there were a similar number of cancelled procedures during a two-month period (19 occasions from September 2014 to the first week of November 2014).
- Between April 2015 and March 2016, there were 52 delayed discharges from the ICU (8% of all discharges from the unit). The Core Standards for intensive Care Units state that discharge from intensive care to a general ward should occur within 4 hours of the decision. Delayed discharges (delayed over 4 hours or more) had consistently been high at over 50% between March and June 2016 (varying between 21% in Feb 2016 and 68% in May 2016 in the 12 months prior to our inspection). Therefore, the unit was not consistently meeting this standard.
- The Core Standards for intensive Care Units state that discharge from the ICU should occur between 7am and 10pm as discharges overnight have been linked with high mortality. The ICU's own discharge policy states, "wherever possible a patient will not be discharged between 8pm and 8am". Data we saw demonstrated that the unit was not adhering to these standards. In the 12 months from July 2015 to June 2016 between 4% and 15% of patient discharges from the ICU were made from 10pm to 7am. Data provided by the Intensive Care National Audit & Research Centre (ICNARC) showed the ICU performed slightly better than average than comparable units did nationally.
- There were 11 non-clinical transfers out of the unit between July 2015 and June 2016. ICNARC data showed the ICU performed slightly worse than average for comparable units nationally (0.6% of all admissions versus 0.5%). The Core Standards for intensive Care Units state that patients should not be transferred to other intensive care units for non-clinical reasons as transferring patients for non-clinical reasons adds the risks, prolongs stay on intensive care and may be associated with distress to patients and their families. The main reason provided by the ICU for non-clinical transfer was lack of bed capacity. Although we saw

Critical care

evidence that these transfers were recorded by staff as incidents on the trust's electronic reporting system there were no recorded action points or lessons learned as there was the expectation that this would be resolved by the opening of the new HDU.

Learning from complaints and concerns

- The ICU received five complaints between May 2015 and April 2016, although the unit matron told us that only two were relevant to the unit directly. We reviewed the two most recent complaints about the ICU and saw that in each case the complaint had been fully investigated by the trust and copies of the reports provided to the family. It was not clear from the information provided to us whether the trust always provided a timely response. In one case where a formal complaint was originally raised in July 2015 a written apology had only been provided in May 2016.
- The unit provided feedback cards for patients and relatives and information on how to make complaints was available within patient information leaflets in the relatives' room.
- Feedback was shared with staff on their "family and patient feedback" noticeboard within the staffroom on the unit and was discussed with the team by the matron as part of the monthly team debrief meeting.
- The unit's psychological support practitioner told us that her role as family liaison had reduced the number of formal complaints as she provided a consistent point of contact for relatives to discuss any concerns early on. The introduction of follow-up clinics for patients after discharge from the unit also provided an opportunity to raise concerns and share feedback with staff. Relatives we spoke with told us they felt comfortable raising any concerns with the nursing staff directly and knew how to access further information if needed.

Are critical care services well-led?

Requires improvement



We rated well led as requires improvement because:

- There was currently no documented long-term strategy for the division and staff had poor awareness of the leadership's plans for the department.
- Senior staff were not fully aware of the latest ICNARC data results.

- There was poor oversight of the acute response team as it was not managed within the department and division. The team's activity was not monitored to ensure the team responded to all referrals promptly. There were no quality indicators developed for the team to monitor effectiveness.
- The risk register did not fully document all risks identified across the unit and senior divisional leaders had limited awareness of key challenges, risks, and serious incidents which occurred on the critical care unit.
- There was no clear audit plan for national, trust and local audits.

However:

- There were plans to develop a long-term strategy with the establishment of a "working group".
- Staff were very positive about local leadership on the unit and spoke highly of the matron and senior nurses.
- There was a positive culture on the unit, staff were friendly and open and felt confident raising concerns.
- The ICU was the first unit in the trust to implement patient diaries and to introduce the role of the psychological support practitioner

Leadership of the service

- The ICU was led by a band 8 matron, supported by a service manager and clinical lead. The matron reported directly to the associate director of nursing for planned care.
- The matron was previously responsible for two ICU units operated by the trust but was now only responsible for Whipps Cross Hospital's ICU. The matron told us her workload was now more manageable and the change had allowed her to focus more fully on local issues.
- There was poor oversight of the acute response team as it was not managed within the department and division. The team was managed within the clinical site management team but was not involved in bed or site management. It was a nurse-led service and the professional lead was the consultant nurse for critical care. The clinical lead for ICU acted as a medical lead. There were plans to move the team under the same division in autumn 2016.

Critical care

- We observed lack of joined up working between the matron and the clinical lead at the ICU unit. Senior divisional leaders had limited awareness of key challenges, risks, and serious incidents which occurred on the critical care unit.
- Staff felt there was strong local nursing lead and were very positive about the matron and senior nurses leading the unit but felt they “could be better supported” by the divisional leadership.

Vision and strategy for the service

- Staff had poor awareness of the strategy for the division. There was lack of long term planning and the unit was focused on opening an additional high dependency unit in September 2016.
- There were plans to develop a long-term strategy in the autumn of 2016 with the establishment of a “working group”. There were also plans to align the acute response team with the ICU.

Governance, risk management and quality measurement

- The unit used quality performance dashboards which collated key performance data such as bed occupancy levels, safety thermometer information and date related to incidents and complaints. Staff working at the unit had mostly good understanding of the local data and knew how ICU performed in relation to key quality indicators. However, they were not aware of critical care beds occupancy level figures reported by the trust to NHS England and could not explain discrepancy in figures collected locally.
- Monthly senior staff meetings attended by various professionals working within the team were used to share learning and discuss audit data, incidents, staffing issues, and practice development areas.
- There were senior nurses meetings where any performance issues, staffing and practice development was discussed with nurses.
- Monthly debrief meetings were used to discuss clinical practice for example practice changes, how to deal with conflicting instructions from clinicians, or ICU admission criteria. Staff also discussed organisational issues such as student nurses support, ordering stock of disposables.
- There was a departmental risk register which noted two risks where equipment was not available to staff, lack of intensivist cover for ill children at the hospital, lack of

outreach service and limited availability of HDU beds. The risk register was reviewed monthly at the senior staff meeting. It was not always clear what actions were taken to minimise the risk, in three out of five cases the risk scoring remained the same after implementing mitigating actions. Senior leaders had limited awareness of unit level risks and incidents reported by ICU.

- There was a data co-ordinator, as well as a band 7 nurse in post who collected data and submitted it to Intensive Care National Audit and Research Centre (ICNARC). Senior staff were not fully aware of the latest ICNARC data results.
- Acute response team activity was not monitored to ensure the team responded to all referrals promptly. There were no quality indicators developed for the team to monitor effectiveness, response times, and if the team responded to tasks as prescribed by the operational policy. It was not clear if all ICU step down patients or all patients with tracheostomy and/or laryngectomy were reviewed by the team, as the hospital did not monitor it.

Culture within the service

- There was a positive culture on the unit, staff were friendly and open and they have not raised concerns about bullying or intimidation.
- Staff completed conflict resolution training as well as equality and diversity training. Matron said they organisés meetings were culture and working relationship among staff were discussed with the team. Staff were also provided with communication training and told us they felt the staff culture had improved since it was provided.

Public and staff engagement

- Feedback and input from previous patients had been sought by the psychological support practitioner (PSP) via the monthly follow up clinics. The PSP worked closely with the speech and language team (SALT) to identify which tools worked best. Feedback from staff and previous patients was being used to assist with this. Patient diaries introduced by the PSP as of research showed that patients often have little or no memory of their ICU stay. They aided in filling in the gaps for patients, and also allow the family an outlet to write to the patient and leave feedback.

Critical care

- Follow up clinics were offered to any patient that spent 72 hours or more in the ICU. They were invited to attend two or three clinics post ICU discharge. Clinics were held monthly and attended by the psychological support practitioner, ICU consultant, senior nurse, and staff nurse, physiotherapists was also involved if required. The aim of the clinic was to review the patient's progress, discuss their admission, recovery, and any problems they had as a result of their ICU stay.
- ICU participated in NHS Friends and Family Test and undertook family satisfaction survey. Although feedback provided by patients and their families was positive we noted that the response rate was very low for both surveys.







Innovation and sustainability

- The service was looking to increase HDU beds availability by eight beds in September 2016. The service did not assess full needs of the local population, be undertaking current needs analyses, to ensure there was a sufficient number of HDU beds to meet the needs of the hospital and the local population, and support the expected level of activity in future. Senior managers told us they were restricted by the environmental constraints when planning the new HDU unit. At the time of inspection, despite the fact there was only two months until opening of the unit, it was not clear how the hospital would ensure they provide the unit with adequate staffing. The business plan informed that recruitment process was to start once business case was approved in October 2015.
- The unit was part of the North East and North Central London adult critical care network group, one of three,

operational delivery networks, for adults in critical care in London. The network covered 15 hospitals in seven NHS Trusts. It helped to share best practice, training initiatives, and review incidents patterns related to critical care across the patch and help to share learning. The network was to introduce peer review across all the units in 2016 to highlighted areas of good practice and highlight areas for improvement. London adult critical care standards were also used in the review process. Clinical lead from the Whipps Cross Hospital participated in the pilot peer review of another hospital which took place in June 2016.

- The ICU was the first unit in the trust to implement patient diaries and to introduce the role of the psychological support practitioner in June 2015. The unit also organised follow up clinics for those who were discharged from the ICU with both families and patients attending them.
- ICU team at Whipps Cross Hospital participated in numerous research initiatives. It included: measurement of exercise tolerance for surgery study, observational study to understand the global impact of severe acute respiratory failure, intensive care global study on severe acute respiratory infection. They also participated in observational study on sepsis and septic shock, observational trial on the factors that indicated fluid challenge, effectiveness and safety of fluid administration, controlled trial to compare a lung-protective mechanical ventilation with conventional ventilation in patients at high or intermediate risk for post-operative respiratory failure.

Maternity and gynaecology

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

Information about the service

- Whipps Cross University Hospital is part of Bart's Health NHS Trust. The maternity services provided at Whipps Cross University Hospital were merged with those provided at the Royal London Hospital and Newham University Hospital in 2012. Bart's Health NHS Trust now provides integrated hospital and community maternity services across all sites.
- The maternity and gynaecology service at Whipps Cross University Hospital is part of the Bart's Health NHS Trust Women's and Children's and Division which also provides gynaecology, genito-urinary medicine, neonatal and paediatric services.
- A total of 4,538 babies were born at Whipps Cross University Hospital between October 2014 and September 2015.
- Whipps Cross University Hospital has a 44 bed ward, Mulberry ward, offering antenatal and postnatal care; 17 rooms in the delivery suite including two high dependency beds, two obstetric theatres and three recovery beds, a bereavement suite, a four day assessment unit (DAU) beds, two rooms in triage, and five birth rooms on Lilac, the alongside birth centre.
- Women can also choose to have a home birth supported by community midwives. Three teams of community midwives provide antenatal care, parent education classes, home births and postnatal care in children's centres, GP surgeries and women's own homes. The maternity services also include specialist provision, for example for women with diabetes and those affected by female genital mutilation (FGM).
- The gynaecology services at Whipps Cross University Hospital offer inpatient care on Pearl Bay, a six bed bay situated on Rowan ward, a mixed female surgical and gynaecology ward, outpatient care and an emergency gynaecology unit (EUG). Outpatient care includes colposcopy, hysteroscopy, treatment for miscarriage and pre-operative assessment. A team of gynaecologists receive support from gynaecology nurses, general nurses and healthcare assistants.
- We visited all wards and departments relevant to the services. For maternity services we spoke with 12 patients, four relatives, 20 midwives and five support workers individually, and six midwives in a focus group. For gynaecology services we spoke with five patients and five nurses. We also spoke with 14 medical staff who worked across both maternity and gynaecology services.

Maternity and gynaecology

Summary of findings

Overall, we rated maternity and gynaecology services as good because:

- Staff planned and delivered care to patients in line with current evidence-based guidance, standards and best practice. For example, we observed that staff carried out care in accordance with National Institute of Health and Care Excellence (NICE) and Royal College of Obstetricians and Gynaecologists (RCOG) guidelines.
- We found all areas of the maternity and gynaecology service we visited to be visibly clean and well maintained.
- Patients and their relatives spoke highly of the care they received in both the maternity and gynaecology services.
- There were good clinical multidisciplinary working relationships. Leaders were visible and approachable.

However:

- Systems, processes and standard operating procedures in maternity and gynaecology were not always reliable or appropriate to keep patients safe.
- The delivery suite had 74 hours of dedicated obstetric consultant cover per week which fell short of the RCOG Safer Childbirth recommendation of 98 hours.
- The ratio of clinical midwives to births was one midwife to 30 women between April and June 2016 which was worse than the national average of one to 28.
- The trust did not provide all patients with one-to-one care during labour which is recommended by the Department of Health.

Are maternity and gynaecology services safe?

Requires improvement



We rated safe as requires improvement because:

- There was one never event in May 2016 which was a retained swab.
- Systems, processes and standard operating procedures in maternity were not always reliable or appropriate to keep patients safe.
- We found that the root cause in serious investigations was not always clearly identified and did not reflect the contributory factors to care delivery problems. For example, in some events a contributory factor may have been the lack of consultant presence on the delivery suite out of hours. We were not assured that this was acknowledged in the findings of investigations or from our discussion with the senior team.
- There was a lack of robust triangulation of action plans developed and subsequently delivered.
- The delivery suite had 74 hours of dedicated obstetric consultant cover per week which fell far short of the Royal College of Obstetricians and Gynaecologists (RCOG) Safer Childbirth recommendation of 98 hours.
- The delivery suite coordinator was not supernumerary and therefore unable to have the constant oversight of delivery suite to manage capacity.
- The trust did not use an acuity tool to monitor activity on delivery suite. There was limited focus on skill mix when planning staffing within clinical areas, particularly those outside delivery suite. Some staff described the staffing on the Mulberry ward as “scary” at times.
- The trust did not provide all patients with one-to-one care during labour which is recommended by the Department of Health. The midwife to birth ratio was 1:30 which was worse than the national average of 1:28.
- Planned staffing levels were not consistently met.
- Not all staff observed the ‘bare below the elbow’ policy.
- We did not see evidence that trust displayed, collected or measured data for the Maternity Safety Thermometer.

However,

- All areas of the maternity and gynaecology service we visited were visibly clean and well maintained with display boards detailing cleanliness and safety

Maternity and gynaecology

information. Portable appliance testing (PAT) or external company servicing of all equipment we looked at was found to be in date, meaning that the equipment was safe for use.

- The practice development midwife (PDM) ran a professional/personal development programme specifically for midwives following a serious incident (SI) that was flexible and could be adapted to the learning required.

Incidents

- There had been one never event in May 2016 which was a retained swab. Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Following the never event, a system was put in place whereby patients wore a pink wrist band and stickers were placed on the medical records to indicate a swab was in situ.
- Staff were able to discuss the process for raising concerns and had a clear understanding of their responsibilities in relation to this. Most staff were confident their concerns were listened to. However, we were told that there had been instances where concerns regarding staffing on the antenatal ward had been raised and the midwife concerned was made to feel their concerns were not taken seriously.
- Escalation of risk was identified through an electronic incident reporting system. The nationally recognised Royal College of Obstetricians and Gynaecologists (RCOG) trigger tool was used for incident reporting. We were told that all incidents were reported according to the Incident reporting system surgeries were held for midwives to improve incident reporting.
- Incidents were flagged via the electronic incident reporting system to the matrons and the head of midwifery (HoM). Incidents graded moderate and above were discussed at the weekly multi-disciplinary risk meeting attended by a consultant obstetrician, HoM, and consultant midwife, governance midwife (chair), representatives from clinical areas and a supervisor of midwives (SoM).
- There was a strong reporting culture in the maternity unit. We saw that 838 maternity and incidents were reported between April 2015 and March 2016. There were 31 gynaecology incidents reported in the same period.
- The top incidents reported were obstetric haemorrhage (97), staff shortage (165), perineal third or fourth degree tears (36), unexpected admission to the neonatal unit (35), poor verbal communication (31), stillbirth or intrauterine death above 24 weeks of pregnancy (31), and shoulder dystocia (26).
- Of the incidents reported, two were catastrophic, seven caused major harm, 91 caused moderate harm, 324 and 406 caused no harm.
- Serious incidents (SIs) were taken to a weekly site based serious incident, risk management and assurance panel (SIRMAP) meeting. A proforma was completed with high level details to enable SIRMAP to determine the level of risk. If an incident was graded as an SI, it was taken to the patient safety meeting who decided who would lead the investigation.
- It was not clear what training investigators had undertaken or how the membership of panels was decided. For example, we reviewed a report written by an obstetric consultant and an obstetric registrar which meant a multidisciplinary approach had not been taken.
- Ten SIs were notified for maternity and one SI was notified for gynaecology to SIRMAP and were reported to the Strategic Executive Information System (STEIS). The maternity SIs included five incidents of poor neonatal outcomes, one antenatal stillbirth, one intrapartum stillbirth and three cases of harm caused during delivery. In addition there were six internal incidents for maternity and two were de-escalated.
- A cluster of unexpected admissions of term babies to neonatal units for cooling had occurred between December 2015 and May 2016. These were subject to an exception report for consideration by the clinical academic group (CAG) board, trust quality and safety board, and trust quality assurance committee. The head of midwifery (HOM) told us that no themes were identified.
- We reviewed five SIs and saw that investigations were investigated using the Serious Incident Framework (2015). We were concerned that the root cause of the incident was not clearly identified and did not reflect the contributory factors to care delivery problems, for

Maternity and gynaecology

example a contributory factor may have been the lack of consultant presence on the delivery suite out of hours; we were not assured from our discussion with the senior team that this was acknowledged.

- We could not see that the effectiveness of interventions was reviewed. Furthermore, there was a lack of robust triangulation of action plans developed. For example, doctors were referred to an educational supervisor and midwives to a SoM but no reference was made to the type or nature of training provided or the outcomes. We noted that all staff involved in incidents where interpretation of cardiotocograph (CTG) readings was a care concern were described as being up to date with CTG training; indicating a lack of triangulation or recognition that CTG training may need to be reviewed.
- We saw the maternity quality assurance and safety committee report for 2015/2016 which was presented to the Perinatal Network Board. This acknowledged there was no observed trend in haemorrhages. CTG interpretation and timely escalation for review was the main concern identified in admission to the neonatal units.
- A number of cross site clinical quality issues were highlighted by the maternity team including variation over time and between sites on emergency C-section rates, and a cluster of babies born at the Barkantine birthing centre that were unexpectedly admitted to the neonatal unit. For Whipps Cross particularly, safeguarding in the vulnerable team and the cluster of unexpected admissions of term babies to neonatal units for cooling mentioned above were identified.
- In response to these concerns and other concerns relating to operational, clinical and strategic challenges, the trust had commissioned an external review to support the improvements in the maternity services.
- The SI relating to gynaecology occurred while the patient was an outlier on another ward. Staff on Rowan ward, which included a six bedded bay for patients receiving gynaecological care, knew about this SI but were unaware of the findings of the report. They gave the impression that, as the incident had occurred on an adjacent ward used for gynaecological outliers, it was not relevant to them.
- We discussed sharing of learning with senior management who acknowledged that historically sharing of learning had not been good. Efforts had been made to address this in the months prior to our inspection. For example, the risk team presented

thematic reviews which had emerged as a result of adverse incidents at the monthly audit. The governance team also attend ward managers' meetings to share and cascade learning from incidents.

- A governance newsletter had been introduced and safety briefings took place at the multidisciplinary handovers and at the daily huddle.
- We saw some good practice based on the learning from SIs. The practice development midwife (PDM) ran a professional/personal development programme specifically for midwives following a SI that was flexible and could be adapted to the learning required.
- A standard operating procedure (SOP) to assist staff in the management of both multiple and preterm birth was developed following a serious incident involving the preterm birth of twins.
- Learning from the never event (a retained swab) was disseminated to staff using a variety of methods including posters, discussion on mandatory training and via the governance newsletter (June 2016). Staff were able to explain when asked the learning and action points as a result of the never event.
- Completed investigations were reviewed in a monthly cross site perinatal health board which enabled learning to be shared across the three maternity units at the trust. However, staff were unable to give any examples of incidents from other sites to confirm this.
- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. We saw evidence of duty of candour both in letters to parents with a full explanation of the duty of candour process including follow up meetings to discuss the results and findings of investigations.

Safety Thermometer

- The NHS Patient Safety Thermometer is an improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enables measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism.
- Whilst we saw evidence within the maternity and gynaecology wards of a safety thermometer which displayed metrics for the number of cardiac arrests,

Maternity and gynaecology

pressure ulcers and acquired infections, we did not see evidence that trust displayed, collected or measured metrics for the Maternity Safety Thermometer. This meant that the public could not readily see the harm specific to maternity care that they may expect to experience.

- The Maternity Safety Thermometer allows maternity teams to take a 'temperature check' on harm and records the proportion of mothers who have experienced harm free care, and also records the number of harm(s) associated with maternity care. It is intended for public display so that the public are informed about the level of harm free care they can expect. The Maternity Safety Thermometer measures harm from perineal and/or abdominal trauma, post-partum haemorrhage, infection, separation from baby and psychological safety. It also records babies with an Apgar score of less than seven at five minutes and/or those who are admitted to a neonatal unit. The Apgar score is an evaluation of the condition of a new-born infant based on a rating of 0, 1, or 2 for each of the five characteristics of colour, heart rate, response to stimulation of the sole of the foot, muscle tone, and respiration with 10 being an optimum score.

Acuity Tool

- Acuity tools are used to measure and respond to capacity on the delivery suite and indicate to staff when the escalated policy should be used to ensure the safety of women and their babies. An escalation plan was in place for periods of increased activity.
- The policy required regular reviews to be undertaken throughout the 24 hour period to monitor activity on the maternity unit. We saw that the trust did not use an acuity tool. Staff would be moved to delivery suite to support as required.

Cleanliness, infection control and hygiene

- We saw that all areas of the maternity and gynaecology service we visited were visibly clean and well maintained. An external company was responsible for cleaning and we saw cleaning schedules on all wards.
- We observed that clinical staff were mostly 'bare below the elbows' however we did observe that some staff who were in uniform were wearing watches and rings.

Hand disinfection dispensers were available inside all entrances to clinical areas and we witnessed staff decontaminating their hand pre and post episodes of care.

- We noted the use of safety bundles for urinary catheter and vascular access in line with NICE QS 61 statement 4 and 5.
- Women admitted for elective caesarean section were routinely screened for Methicillin-resistant Staphylococcus aureus (MRSA) in line with recommended practice.
- The trust provided us with information that demonstrated there had not been any cases of Clostridium difficile infection or MRSA in the maternity or gynaecology services between April 2015 and March 2016.
- Compliance with hand hygiene for 95% delivery suite, 97% for the Mulberry ward and 67% for the Emergency Gynaecology Unit (EGU) between October 2015 and March 2016 in comparison to the trust target of 90%.
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- The trust provided us with information that demonstrated there had not been any cases of MRSA in the maternity or gynaecology services between
- Trust records showed compliance with hand hygiene was 95% for the delivery suite, 97% for the Mulberry ward and 67% for the emergency gynaecology unit (EGU) between October 2015 and March 2016 in comparison to the trust target of 90%.

Maternity and gynaecology

- We saw that equipment was labelled with tags to indicate when it had been cleaned. Sluice areas were clean and had appropriate disposal facilities, including for disposal of placentae.

Environment and equipment

- The maternity service was part of the 'Transforming Services Together' project which acknowledged that maternity care facilities at Whipps Cross had historically been subject to under investment.
- The fabric of the building housing the maternity services was old and whilst efforts were made with clinical areas it was evident that non patient areas such as visitor toilets have not been subject to the same level of investment. The delivery suite had been extended and there was a disparity in size of the rooms between old and new. The old rooms were tiny and cramped. Similarly the triage area within the delivery suite was cramped and had no natural light.
- All equipment on the delivery suite was visibly clean and in a good state of repair. However, staff reported that equipment such as electronic blood pressure monitoring and digital thermometers were in short supply on the ante and postnatal ward.
- The community midwives reported that the service did not have equipment such as transcutaneous bilirubin meters (machines that test for jaundice in babies) which resulted in babies needing to be referred to children's emergency department for blood tests to estimate bilirubin levels.
- Resuscitation equipment for adults and newborn were readily available, clean, fit for purpose and checked daily with no gaps in checking. However, we only had access to three rooms on delivery suite due to high activity.
- The fetal blood gas analyser was clean and in good state of repair.
- Although the delivery suite had one telemetry (wireless CTG machine) apparatus this was unavailable at the time of our inspection and therefore limited access to the birthing pool for high risk women and those who wished to be mobile in labour.
- Rowan ward had a pregnancy loss refrigerator. Over the three months prior to our inspection, there were gaps in the daily checking and recording of fridge temperatures of on average of four to six consecutive days. There was

a daily log of specimens with recording of when the specimen was transported to either the mortuary or histopathology; however it was noted that staff used their initials rather than signature.

- There was a reliance on haemacue estimates rather than the blood gas machine for haemoglobin blood tests for women experiencing a postpartum haemorrhage. This meant that the most accurate result was not being obtained nor was useful information such as serum lactate level, which is important for Sepsis Six management (Sepsis Six is the name given to a bundle of medical therapies designed to reduce the mortality of patients with sepsis).
- An intercom and buzzer system was in use to gain entry to the delivery suite and Mulberry wards. This meant that staff could identify visitors and ensure that women and their babies were kept safe.
- 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.
- Maternity staff we spoke with knew the birth pool cleaning and evacuation procedures.
- We saw sharps bins on the floor in triage. The Health and Safety Executive guidance is that sharps containers should not be placed on the floor, window sills or above shoulder level. They should be stored above knee level and below shoulder level to minimise the risk of needle stick injuries.

Medicines

- Medicines, including controlled drugs and intravenous fluids on the delivery suite, Lilac Birth Centre and Rowan ward were appropriately stored.
- Controlled drugs were checked twice daily and records demonstrated that there were no gaps in checking.
- Drugs which required storage in a fridge were stored in a clinical room with coded access both on the door and the fridge. 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.
- Medicines supplied and administered under Midwives Exemptions under the Medicines Act as well as those administered under a Patient Group Direction were appropriate.

Maternity and gynaecology

- We reviewed four prescription charts that had documentary evidence that drug allergies, if applicable, had been recorded.

Records

- We saw that patient records were stored securely in lockable cabinets on the gynaecology and Mulberry wards.

Maternity Records

- The maternity service used the West Midlands Perinatal Institute antenatal hand held notes. The booking visit was recorded electronically; a hard copy was printed off and inserted into the hand held record.
- We reviewed five sets of records all of which conformed to the record keeping standard of entries being dated, timed and accompanied by a legible signature and identifiable name. The intrapartum record including the partogram was electronic and thus only the minimum data set was available to review in the hospital records.
- On the Mulberry ward we saw personal child health record (red books) were introduced for each new born. Red books are used nationally to track a baby's growth, vaccinations and development.

Gynaecology records

- We reviewed one set of gynaecology records and saw that the patient demographics were incomplete, an initial assessment had not been completed and pain was not assessed.

Safeguarding

- Arrangements were in place to safeguard adults and babies from abuse, harm and neglect and reflected up to date safeguarding legislation and national and local policy.
- Staff we spoke with demonstrated an understanding of the trust's safeguarding procedures and its reporting process.
- We were told by senior staff that all midwives and maternity care assistants had access to level three safeguarding children training in line with the intercollegiate document (2015). Safeguarding training compliance at level three was recorded at 92% compared to the trust target of 90%.

- There was a child and baby abduction policy in place to ensure the safety of babies whilst on trust premises. This included taking measures to ensure the security and prevention of baby/child abduction, as defined under the Child Abduction Act 1984.
- The trust provided evidence that 100% of staff had been trained to safeguard people at risk of and treat those affected by female genital mutilation (FGM). We reviewed the FGM guideline and saw that it corresponded to statutory guidance. Staff were aware of their responsibility to report suspected or possible FGM.
- Midwifery staff told us of, and we saw, evidence of systems in place to monitor the disclosure of domestic abuse in line with Domestic violence and abuse: how health services, social care and the organisations they work with can respond effectively and that disclosure was recorded.
- There was a did not attend (DNA) policy that the trust adhered to. This meant that staff were aware of women who had missed appointments and could arrange follow up to ensure that women attended for care, and safeguarding concerns were raised when they did not do so.
- Safeguarding supervision is a Department of Health requirement (Working Together to Safeguard Children, 2015). When asked, community midwives told us they did not receive safeguarding supervision. We spoke with senior staff about the provision of safeguarding supervision and were told that the trust did not provide this for staff working in maternity services.

Mandatory training

- A practice development midwife (PDM) was in post responsible for mandatory training who was committed and dynamic. There was a booking process for all managers to access and staff were booked onto mandatory training by the PDM.
- Face to face mandatory and clinical updates were covered over three or four days across each site. Staff reported that they did not experience any problems accessing the three day mandatory training programme.
- Compliance with two yearly fire, manual handling and basic life support was 92% in 2014 and all staff were booked to attend sessions in 2016.
- Compliance with annual specific maternity mandatory training was 93% in 2015.
- Specific maternity mandatory training was standardised across the three sites based on the PROMPT (Practical

Maternity and gynaecology

Obstetric Multi-Professional Training) RCOG Model. Pre-reading literature (PROMPT Manual) was provided for all staff. Training covered: multidisciplinary obstetrics team training (MOTT); CTG update; neonatal resuscitation; safeguarding; promoting normality; communication skills focussed on kindness and compassion in delivery care; and care of the deteriorating patient.

- Obstetric emergencies training including eclampsia, sepsis, shoulder dystocia (difficulty in delivery of the baby's shoulders), obstetric haemorrhage, breech, cord prolapse and neonatal resuscitation was delivered using simulated learning in groups. On the spot feedback was provided as well as individual written feedback.
- CTG machines were used by midwives on the delivery suite to measure contractions and baby's heart rate over a period of time. A CTG update was a taught session following by an assessment paper. Individual feedback was given to staff by the PDM and ongoing support and development was provided until the midwife felt confident and was competent in CTG interpretation.
- The sepsis station was new but enabled Sepsis 6 to be reiterated including opportunities to use MEOWS charts and discuss fluid balance and management.
- A 'Prep' (post-registration education and practice) handbook that enabled reflection in practice was provided to all midwives during the mandatory training week.
- A trust mandatory training handbook contained three quizzes, information governance, safeguarding level two and medicines management. Staff were required to fax confirmation of completion to the mandatory training management team.

Assessing and responding to patient risk

- For women using maternity services the booking visit took place before 12 weeks of pregnancy. A detailed risk assessment was carried out during the booking visit and again at 36 weeks of pregnancy. Similarly lifestyle considerations such as the importance of maintaining adequate vitamin D stores during pregnancy and whilst breastfeeding were also discussed and documented. Between April and June 2016, 50.4% of women were seen by a midwife by the completed 10th week of pregnancy. Staff told us that this was largely due to the demographic of the local population.
- An antenatal and newborn screening coordinator was responsible for antenatal and newborn screening. NHS

England collects data on nine key performance indicators (KPIs) for screening including the number of women tested for HIV, the number of women referred for Hep. B specialist assessment, the number of completed laboratory request forms for Down's syndrome screening, the number of women tested for sickle cell and thalassaemia, the number of women tested by 10 weeks gestation and the number of laboratory requests with completed Family Origin Questionnaire, the number of avoidable repeats for new born blood spot test, and the number of babies having a Newborn and Infant Physical Examination (NIPE).

- Data provided by the trust demonstrated compliance with most of the KPIs. One exception was the timeliness of women tested for sickle cell and thalassaemia number. The reason for this was not due to lack of service provision but due to the majority of this demographic of patients who presented for antenatal care (self and GP referral) after 10 weeks gestation. The other exception was the number of avoidable repeats for the new born blood spot test. Reasons for this were documented and a mandatory e-learning module was in place. Data was not collected for the number of babies having NIPE.
- Whipps Cross Hospital offered a fetal medicine service and a maternal medicine service led by the lead obstetrician. There were close links with the tertiary level service at The Royal London Hospital where the consultant led these services for Whipps Cross patients to offer them continuity of care.
- Women who had problems in pregnancy were reviewed on the maternity assessment unit. From here they could be admitted to the ward for short periods of time to be reviewed regularly by the obstetric staff.
- NHS England's 'Saving babies' lives' care bundle (2014) for stillbirth recommends measuring and recording fetal growth, counselling women regarding fetal movements and smoking cessation, and monitoring babies at risk during labour. The trust had developed a care pathway for women who experienced a change in or absent fetal movements.
- The fetal growth assessment protocol (GAP) charts were introduced in the Whipps Cross University Hospital maternity unit in 2014. Customised fetal growth charts were in use and completed to help identify babies who were not growing as well as expected. This meant that women could be referred for further scans and plans made for their pregnancy.

Maternity and gynaecology

- At the time of inspection, the trust did not have a service level agreement to be able to offer an immunisation programme to pregnant women. However, the consultant midwife informed us of a planned new development to create bespoke immunisation teams in all three community areas.
- Consultant obstetric presence on the delivery suite was until 10pm Monday to Friday and on-call outside of these hours. During the review of five serious incidents we were not assured that senior obstetric help or advice was being sought out of hours or that the lack of consultant presence was not contributory to these incidents.
- Interpretation of fetal heart rate in labour was based on NICE 2007 guidance rather than 2014. The service had clear mitigation for this and had a clear strategy to await universal agreement on optimal recommendations. Senior midwives provided CTG review known as 'fresh eyes' in accordance with NICE Intrapartum Guidelines. It involved the delivery suite coordinator checking a CTG recording of a baby's heart rate to ensure that it was within normal parameters. Trust records showed there was 80% compliance of 'fresh eyes' in the CTG audit conducted in June 2016. However, staff told us if the CTG was normal, 'fresh eyes' review did not happen which meant that babies at risk may not be identified.
- Maternity staff used the modified early obstetric warning score (MEOWS) to monitor women in labour and to detect the ill or deteriorating patient. We saw that observations were recorded and scored appropriately. However, a trust wide audit conducted from 1 December 2015 to 28 February 2016 found: 34% of notes audited had clear instructions on frequency of observations; 75% of charts showed MEOWS calculation; 59% of patients who "triggered" were referred for a medical review with reasons for escalation written in 52% of notes.
- A sepsis trolley with all required equipment had been established to speed up the response to managing patients with sepsis. We saw evidence of posters alerting staff to the importance of the early recognition of sepsis and observed that staff were familiar with this.
- Women requiring management of complications were cared for in one of the two high dependency rooms on delivery suite. Care was provided by a midwife trained in high dependency care. We were told that the service had a critical outreach team who were available to offer support to staff caring for women requiring high dependency care. However, some staff were not confident this happened in practice. Any patient who needed additional support and care was transferred to the intensive therapy unit (ITU). Staff told us that transfer from delivery suite to ITU was by emergency ambulance due to the lack of direct corridor access to the main hospital.
- There was a clear transfer in labour pathway for patients requiring transfer from the low risk birth setting to the consultant led delivery suite. For those patients whose babies were born before arrival there was local agreement that community midwives would attend during the day and a unit midwife out of hours.
- There were arrangements in place to ensure clinical checks were made prior to, during and after surgical procedures in accordance with best practice principles. This included completion of the World Health Organisation's (WHO) Five Steps to Safer Surgery' guidelines. We observed the process and documentary evidence that confirmed all the stages were completed correctly and that checklists showed that this was usual practice. The trust provided evidence of 100% compliance with this between February and April 2016. A category one caesarean section WHO Safety Checklist was implemented as a result of the last CQC report.
- We observed the briefing that took place between the elective and emergency teams which included the consultant anaesthetist covering delivery suite who was able to provide information about the predicted emergency workload.
- NHS Safety Alert 1229: Reducing the risk of retained swabs after vaginal birth and perineal suturing states that swabs should be counted whenever they are used. The unit had one never event concerning swab counting. Trust records showed compliance with swab and needle counting for delivery suite was 50% in February 2016 and 65% in May 2016. This meant that women were not protected from the risk of a retained swab.
- Midwifery handover took place at the change of each shift. Handover included a review of all women on the wards and allocation of work.
- Formal multidisciplinary handovers were carried out four times during each day on the delivery suite, attended by medical staff and the delivery suite coordinator. We observed the 8.30am handover which was structured and included discussion on all maternity and gynaecology inpatients and overnight deliveries.

Maternity and gynaecology

Care was assessed and planned at this handover and work allocated to the appropriate doctor. Following the obstetric handover we witnessed the multi-disciplinary daily CTG teaching session which was delivered by the obstetric consultant.

- Maternity and gynaecological patients having elective surgery attended dedicated pre assessment clinics. The anaesthetic service operated an antenatal clinic for the referral of high risk women to ensure that intrapartum plans were formulated in advance.

Midwifery staffing

- Birthrate Plus® is a midwifery workforce planning tool which demonstrates required versus actual staffing need to provide services. Birthrate Plus® is recommended by the Department of Health; endorsed by the Royal College of Midwives and incorporated within standards issued by the NHS Litigation Authority. It enables the workforce impact of planned change(s) to be clearly mapped, in order to support service improvement and planning for personalised maternity services.
- We saw documentary evidence that Birthrate Plus® recommended a midwife to birth ratio for 1:26 for Whipps Cross. This was lower than the national average of 1:28 to take account of the complexity of the women who birth at the hospital. We saw evidence that the midwife to birth ratio was 1:30.
- We were told that the service strives to provide 1:1 care in labour. We saw from the Delivery Suite Safety Thermometer this was not achieved on two occasions in July 2016. We did not see any Safety Thermometer data on Lilac Birth Centre. Staff on Lilac reported that they were always able to offer 1:1 care, however on closer scrutiny at periods of high activity they were required to care for postnatal women as well as labourers.
- We did not see any evidence that the service used NICE NG4 Staffing Red Flags. There was a daily 10am safety huddle which was attended by midwifery representatives from each clinical area. Staff told us that this was a recent innovation and were complimentary stating that it provided an overview of activity in each area and felt it facilitated and fostered collaborative team working.
- We observed two safety huddles, one led by a matron, the other led by the head of midwifery. Staffing was reviewed and staff moved if needed to cover shortfalls. Safety briefs were given and staff informed of updated guidelines such as Group B Haemolytic Streptococcus (GBS), postpartum haemorrhage (PPH) and the intrapartum care bundle. We observed that a proforma or agenda was not used and that focus drifted from time to time. At one huddle, it was identified that the night shift required two midwives; a message was circulated to offer the shifts to staff.
- The head of midwifery and the education facilitator told us that controls were applied to limit the number of preceptorship midwives. At the safety huddle we witnessed that the focus of staffing was the number of staff with little regard for skill mix within clinical areas, particularly those outside delivery suite. This was substantiated by midwives who described the staffing on the Mulberry ward as “scary” at times and we were told of an incident in which two preceptorship midwives were left in charge of the antenatal inpatient area.
- We were told and saw documentary evidence that the vacancy rate was 8.3 whole time equivalent (WTE); the sickness rate was 3.3% WTE and maternity leave rate was 6.3%WTE.
- Midwives worked a mixture of eight and 12 hour shifts. Delivery suite coordinators are responsible for the management of the activity on the ward and require constant oversight of the ward so that decisions can be made regarding care and treatment and flow of patients. We saw that the band 7 delivery suite coordinator was included in the staff rotas and therefore not able to have the constant oversight required. The trust told us that they worked in a supervisory capacity and did not provide 1:1 care in labour. Once full recruitment was established, there would be the opportunity to progress to the labour ward coordinator to being supernumerary.
- The planned and actual staffing levels were displayed at the entrance to each Mulberry ward. The delivery suite required 11 midwives per shift on weekdays and 10 midwives per shift at the weekends. We saw evidence from the safety thermometer boards that planned versus actual staffing levels were not always achieved; there had been five occasions during July when planned staffing levels for midwives had not been achieved.
- A dedicated theatre team meant that midwives were not taken from delivery suite to work in theatre. However, a midwife support worker (MSW) was used to run in

Maternity and gynaecology

theatre out of hours. Staff told us that in some cases a team was taken from delivery suite and identified this happened when two emergencies happened at the same time at the weekend.

- Staffing requirements for the Mulberry ward was five midwives and three MSWs on the early shift, five midwives and two MSWs on the late shift and four midwives and two MSWs on the night shift. There was also a neonatal nurse and a nursery nurse on duty Monday to Friday. We saw actual staffing met required staffing levels on this ward during our inspection. Patients and staff told us staffing was inadequate on Mulberry ward at night time.
- Staffing requirements for the birth centre was two midwives and one support worker. Staff on Lilac Birth Centre told us that during high activity they were frequently moved to the high risk delivery suite, but said this had decreased recently. This was substantiated by the head of midwifery who also reported that use of agency midwives had decreased substantially over the last few months. We saw on our inspection that a midwife took a patient from Lilac Birth Centre to delivery suite for an epidural to be sited. The midwife stayed with the patient which left one midwife and a support worker on the birth centre. This meant that the birth centre could not take another labouring woman.
- Staffing requirements for triage was one midwife, one support worker and a receptionist who was present from 7am until 3pm daily. We saw that required and actual staffing was met on triage during our inspection. All telephone triage was conducted through and by the triage area. This was an issue as the triage area was staffed by one midwife. Calls were initially fielded by a receptionist who then liaised with the midwife and relayed the information back to the woman. NICE Intrapartum (2014) 1.3.5 states 'Consider an early assessment of labour by telephone triage provided by a dedicated triage midwife for all women'. The receptionist often stayed after hours if the unit was busy as they were 'their only support'.
- Staffing requirements for the day assessment unit (DAU) was two midwives and one support worker.
- The maternity unit used agency staff and had its own bank of temporary staff which was made up of permanent staff who undertook extra work to cover

shortfalls. Bank midwives undertook the same mandatory training as substantive staff. However, the trust relied on agencies to provide training for agency midwives.

- Birthrate Plus® recommendation is that community midwives have caseloads of 1:96. The trust was using a team model and therefore could not provide individual caseload numbers.
- The homebirth team of four midwives was part of the community establishment. At the time of our inspection there were three vacancies in the team. Shortfalls were covered by community midwives on call.
- The trust was in the process of collating evidence on community midwives' workloads as part of plans to transform services.
- There was a lone worker policy which community midwives adhered to.

Nursing staffing Gynaecology

- There was one trained gynaecology nurse on Rowan ward who worked Monday to Friday day shifts only. This meant that patients were cared for by nurses without training in gynaecology after 6pm and at weekends.
- A patient with specific needs told us that she did not see a stoma nurse during her stay on Rowan ward.
- The emergency gynaecology unit (EGU) required a minimum of three nurses and one care assistant for each shift. We saw that the actual staffing on duty met this. In times of shortfalls, staff worked on extra shifts or worked as bank staff; we saw that 12 bank shifts had been used between March and June 2016.

Medical staffing

- The trust employed 90 WTE medical staff in the maternity and gynaecology services. The level of consultant cover was 31% which was lower than the national average of 40%. The percentage of registrars was 55% which was greater than the national average of 46%. The percentage of middle grade doctors was 7% which was similar to the national average of 8%. There were 7% junior grade doctors which was similar to the national average of 6%.
- There were 74 hours of consultant cover per week on the delivery suite which is less than the RCOG Safer Childbirth recommendation of 98 hours. At the time of the inspection a consultant was present on the delivery suite daily from 8am until 10pm Monday to Friday, and

Maternity and gynaecology

for two hours on Saturdays and Sundays. Out of hours cover was provided by the consultant on call; two consultants covered the weekend. A second consultant attended delivery suite for elective caesarean sections.

- A dedicated 'hot week' consultant was available from 8am until 5pm daily and on call out of hours.
- We were told that revisions to job plans were on hold until after our inspection. Two new consultants had been appointed and were due to start work at the hospital in September 2016.
- A dedicated registrar was on delivery suite each 24 hours. Senior house officers (SHOs) were on duty from 8am to 5.30 pm. At night two specialist trainees were on duty, one for obstetrics and one for gynaecology. One SHO was also on duty at night time covering both services.
- The maternity service had approved safe staffing levels for obstetric anaesthetists and their assistants, which were in line with Safer Childbirth (RCOG 2007) recommendations. A consultant anaesthetist provided cover for delivery suite between 9.00am and 5.00pm weekdays; a separate consultant anaesthetist was provided for the elective caesarean section list three mornings a week. Out of hours cover was provided by the on-call consultant.
- The gynaecology service was covered by a registrar and a senior house officer. Consultant cover was provided by the 'hot week' consultant. The consultant on call at weekends covered both maternity and gynaecology.
- Emergency surgery was managed in accordance with National Confidential Enquiry into Patient Outcome and Death (NCEPOD) by consultants and/or middle grade staff.

Major incident awareness and training

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

Are maternity and gynaecology services effective?

Good



We rated effective as good because:

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

The trust had merged 57 maternity and gynaecology guidelines across all the Bart's sites. The guidelines were benchmarked against National Institute for Clinical Excellence (NICE) guidance; 41 guidelines were fully compliant, eight were partially compliant and two were awaiting approval.

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

However:

- Care and treatment did not always reflect current evidence-based guidance.
- Only 11% of women had a named midwife.

Evidence-based care and treatment: Maternity

- Policies were based on national guidance produced by NICE and the Royal Colleges. All guidelines were synchronised across Bart's Health Care following a robust ratification process. Staff had access to guidance, policies and procedures via the trust intranet. Hard copies were also available in ward areas.
- 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.
- We found from our discussions with staff and from observations that care was mostly being provided in line with the NICE Quality Standard 22. This quality standard

Maternity and gynaecology

covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.

- Antenatal care provision was not in line with NICE QS22 Quality Standard 2 which states that pregnant women should be cared for by a named midwife throughout their pregnancy. Only 11% of women had a named midwife.
- The booking appointment is the first appointment with a midwife when medical, obstetric and social histories are recorded, risk assessments carried out, options discussed and plans made for pregnancy. The initial booking history was taken by a dedicated team of midwives based at the hospital who then referred the patient to a community midwifery team. All women therefore had to travel to the hospital for their booking appointment. The trust said this was because poor access to IT systems meant the community midwives could not do the booking visit. The community midwifery service was being process mapped as part of the trust's strategy to improve the maternity services, Transforming Maternity Services Together (TST).
- We saw evidence that the trust was aware that women said they did not see the same midwife most of the time and, as part of TST, it was planned that a patient would be cared for by no more than three midwives and all women would have a named midwife.
- One of the aims of TST project was to address the named midwife. 'Pregnancy Circles' is an outreach pregnancy programme providing a named midwife from 16 weeks onwards and was due to be launched at Whipps Cross at the time of our inspection. The first cohort of women were being recruited and the community midwives hoped that once the pilot had been audited and evaluated that it would be rolled out throughout the community areas.
- The trust offered screening in line with the National Screening Committee (NSC) recommendations. Patients were supported to make decisions around screening and were provided with the NSC leaflet at booking. We saw documentary evidence to show that the 10 week KPI for haemoglobinopathy screening was 16.6% compared to the target of 50%, and the uptake for Down's screening was 95.7% compared to the target of 97%. The mitigation for the low level for haemoglobinopathy screening was the vast majority of this demographic of clients presented for antenatal care (self and GP referral) after 10 weeks of pregnancy; the performance figure was not due to lack of service provision.
- We found evidence to demonstrate that women were being cared for in accordance with NICE Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, and care of the new born baby.
- Midwife led care was offered to all low risk women in line with NICE guidance CG62 Antenatal Care for uncomplicated pregnancies. Following discussion at 36 weeks, a birth plan was made and a place of birth sticker was attached to the hand held records. The sticker had the telephone numbers of intended place of birth. Lilac Birth Centre was the default place of birth for all low risk women. However, all women, irrespective of risk, were triaged through the delivery suite.
- Midwives we spoke with in the birth centre were concerned that often women who were struggling in latent phase were admitted to the antenatal ward and could be subject to unnecessary interventions because of the inability of busy midwives to offer appropriate support in the latent phase of labour. The consultant midwife told us of plans to create a sensory room within the birth centre for women who were in the latent phase of labour who did not want to continue their care at home.
- The induction of labour (IOL) pathway had been changed from an inpatient to ambulatory service. Service users were consulted through the Maternity Services Liaison Committee (MSLC) and other patient forum groups. Every step of patient's journey through the IOL pathway was process mapped. The induction drug was changed from Prostaglandin (a gel that cannot be removed) to Propess (a tampon containing slow release medicine which can be removed). Following this the pathway was changed and patients went into the hospital to have Propess inserted and then went home, with the exception of high risk women who were admitted and had IOL as an inpatient. Staff told us the impact was almost immediate, the number of complaints relating to IOL reduced and an impact on reducing lower segment caesarean section rate was noted.
- The fetal monitoring guideline was not compatible with NICE (2014) recommendations for categorising fetal

Maternity and gynaecology

heart rate monitoring during labour and the trust was still using the 2007 NICE guidance. The trust mitigated against this by clearly stating in the guideline that this was the case.

- The maternity service had enrolled in the NHS Litigation Authority “Sign Up for Safety – Reducing Intrapartum stillbirth” (Sign up to Safety is a national initiative to help NHS organisations and their staff achieve their patient safety aspirations and care for their patients in the safest way possible. At the heart of Sign up to Safety is the philosophy of locally led, self-directed safety improvement).
- A £500,000 plus amount had been awarded which was used to implement K2 Guardian as part of an Intrapartum Care Bundle. The K2 system provides an e-record of CTG and also provides accessibility to consultants and senior midwives via a central monitor; staff were on training for this at the time of our visit. The bundle also included a decision making tool for on-going risk assessment and a care plan sticker which would be completed hourly, signed and attached to the labour record.
- We saw from our observation of activity and from reviewing care records that the care of women who planned for or needed a caesarean section was managed in accordance with NICE Quality Standard 132.
- We saw that there was a vaginal birth after caesarean (VBAC) clinic held by the consultant midwife using a pathway aimed at reducing the caesarean section rate. A breech clinic had been introduced in response to the number of breech presentations; external cephalic version (turning the baby) was offered and plans made for delivery.
- We saw that an enhanced recovery programme was used for women having elective caesarean sections which meant that women were prepared and underwent early transfer home.
- There was evidence to indicate that NICE Quality Standard 37 guidance was being adhered to in respect of postnatal care. This included the care and support that every woman, their baby and, as appropriate, their partner and family should expect to receive during the postnatal period. On the post-natal ward staff supported women with breast feeding and caring for their baby prior to discharge.
- We found from our discussions and from observations that care was being provided in line with the NICE Clinical Guideline (CG110) Pregnancy and complex

social factors: A model for service provision for pregnant women with complex social factors. This guideline covers the care of vulnerable women including teenagers, substance misuse, asylum seekers and those subject to domestic abuse.

Evidence-based care and treatment: Gynaecology

- Minimally invasive access surgery was undertaken on a day case basis. The expectation was that the woman went home on the day of the procedure.
- Whipps Cross was an accredited British Society for Gynaecological Endoscopy (BSGE) endometriosis centre.
- A specialist cancer pathway was in place and the trust had increased the number of gynae- oncologists to match the increase in referrals which had doubled over the previous four years.

Audit

- The trust participated in national audits including the National Screening Committee Antenatal and Newborn Screening audit, the National Diabetes in Pregnancy Audit and the national report for perinatal mortality for births: Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE).
- The trust provided us with a rigorous and robust audit programme for 2016 which showed 26 obstetric audits listed. At the time of our inspection, 12 audits had been completed and nine had been presented and discussed at the clinical governance and audit meeting which was open to all staff. We saw that data was analysed and that recommendations and action plans were made as a result of audits.
- Examples of obstetric audits included grown assessment protocol (GAP); ambulatory induction of labour; postpartum haemorrhage; birth options; severely ill pregnant women and use of MEOs; and WHO Surgery checklist.
- The fetal growth assessment protocol (GAP) charts were introduced in the Whipps Cross University Hospital Maternity unit in 2014. An audit of 500 notes demonstrated that 246 (49%) charts were in the patient notes at the time of delivery. Of those measurements were plotted on 29% (146). An action plan was in place to hold more training and re-audit. However, fetal growth assessment was not on the mandatory training for 2016.

Maternity and gynaecology

- A retrospective audit of 50 antenatal and 50 intrapartum CTGs was conducted for compliance with the trust's continuous electronic fetal monitoring guideline. Compliance with six indicators was measured and recommendations made. A further audit of 16 records of CTGs demonstrated 80% compliance in May 2016, 84% compliance in June 2016 and 100% in July 2016 (four notes only as the month was not complete).
- Examples of gynaecology audits included colposcopy patient survey, postoperative complications of surgery, medical management of miscarriage and MVA.
- The trust had benchmarked maternity services against the recommendations of the national report for perinatal mortality for births: Babies Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) and the Overview of Saving Lives, Improving Mothers' Care Lessons learned to inform future maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2009-2012. The service also ensured that all births between the gestational ages of 22 weeks and 23 weeks and six days were reported to MBRRACE.
- The trust was compliant with all recommendations with the exception of increasing immunisation rates in pregnancy against seasonal influenza, access to antenatal care and the publication of multi-agency evidence based operational guidance for the care of pregnant women with epilepsy. Plans were in place to address these with deadlines for compliance.
- The government National Maternity Review report, Better Births, published in February 2016 made recommendations based on seven themes: personalised care, continuity of carer, safer care, better postnatal and perinatal mental health care, multi-professional working, working across boundaries and a fairer payment system. The trust had reviewed its maternity service and found that its strategy Transforming Service Together (TST) was compliant with the recommendations of the report.
- The average time for women requesting and epidural was audited and was within the audit standard of 30 minutes. However, we saw that a woman who had requested an epidural waited for an anaesthetist to become available; she was offered alternative pain relief until the anaesthetist was free.
- Women using the Lilac Birth Centre could be given diamorphine if requested. Water birth and immersion in water in labour was available in both low and high risk settings. There were no alternative pain relieving services such as hypnobirthing or aromatherapy on offer.
- Women we spoke with in maternity and gynaecology felt that their pain and administration of pain relieving medicines was well managed.

Nutrition and hydration

- The infant feeding midwife was responsible for the oversight of infant feeding. The trust promoted breastfeeding and the health benefits known to exist for both the mother and her baby. The trust policy aimed to ensure that the health benefits of breastfeeding and the potential health risks of artificial feeding were discussed with all women to assist them to make an informed choice about how to feed their baby.
- Whipps Cross University Hospital was awarded UNICEF Baby Friendly Initiative stage one accreditation in June 2016. This meant that the trust supported women and babies with their infant feeding choices and encouraged the development of close and loving relationships between parents and baby.
- Women told us that they received support to feed their babies. We saw that the initiation of breastfeeding rate was 81% which was better than the national average of 75%.
- Patients told us that food was available outside of set meal times if they did not feel like eating or were unable to eat at set meal times.

Patient outcomes: Maternity

- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) guideline recommends the use of a maternity dashboard. The maternity dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance

Pain relief

- The service offered a comprehensive range of pharmacological and non-pharmacological methods of pain relief including Tens machines and Entonox, a ready to use medical gas mixture of 50% nitrous oxide and 50% oxygen that provides short term pain relief, and a 24 hour epidural service.

Maternity and gynaecology

in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.

- Information on the dashboard from April to June 2016 demonstrated that:
- 84.8% of births took place on delivery suite and 13.2% took place in the Lilac Birth Centre.
- Seven antepartum stillbirths occurred which equated to 3.19%, which was below the MBACE average of 4.55%. There had been no intrapartum stillbirths. Whipps Cross was amongst the lowest 10% of pregnancy loss recorded by MBACE.
- The vaginal delivery rate was 59.8%, similar to the RCOG recommendation of 60%. Of these 27% were unassisted births (births that do not require episiotomy or other intervention).
- The homebirth rate was 1.5% which was lower than the trust target of 2% and national average of 2.3%.
- The induction rate was 24.4% which was similar to the trust target of 24% and the above national target of 22%.
- The caesarean section rate was 26.7%, which was worse than the trust target of 24% and slightly above the national average of 25%.
- The elective caesarean section rate was 9.2% compared to the trust target of 11.2% and the national average 10.7%
- The emergency caesarean rate was 17.5% compared to the trust target of 15.2% the national average of 14.7%.
- The instrumental delivery rate was 9.2% compared to the trust target of 14.9%.
- The third or fourth degree tear rate was 2.1% compared to the trust target of 2%.
- The trust recorded postpartum haemorrhage (PPH) above 1.5 litres on the dashboard and 2.1% of patients had experienced PPH compared to the trust target of 4%.
- 55 term babies were admitted to the Neonatal Unit and 18 required transitional care.
- The transfer rate from the birth centre to delivery suite was not recorded on the dashboard.
- The latest CQC Intelligent Monitoring report (May 2016) found three maternity outliers for Whipps Cross Hospital. These were two cases of caesarean section

and one case of puerperal sepsis. The CQC expert panel had approved the trust's action plans and considered them to be an appropriate means of addressing concerns identified by the trust's review of the alert.

- The trust did not meet any of the five standards in the National Neonatal Audit Programme 2013. One standard related to maternity care, the remainder to neonatal care. The hospital did not have a level three neonatal unit and therefore transferred all babies at or below 28 weeks out to other neonatal units. The percentage of mothers who received a dose of antenatal steroids was 84% compared to the target of 85%.

Patient outcomes: Gynaecology

- Examinations, scans, treatment plans and assessments were carried out in the gynaecology outpatient department during the week. A team of professional staff supported patients in investigative procedures, giving advice as necessary. Emergency scans and assessments were available out of hours. We were told that there was a gynaecology operation scheduled on most days.
- Gynaecology activity was recorded on the Gynae Network Scorecard. The trust provided activity data for April 2015 to March 2016 that demonstrated the following:
 - 11,088 referrals were made to the service
 - 8,556 new outpatient appointments
 - 8,531 follow up appointments
 - 801 day case operations
 - 601 elective operations
 - 799 emergency operations
 - 23 medical terminations of pregnancy

Competent staff

Maternity

- An induction period of two weeks orientation was offered to newly appointed staff. In addition, all newly qualified midwives undertook a nine month competency based preceptorship programme 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.
- In addition to the nine month programme the trust offered an alongside 18 month programme. The lead

Maternity and gynaecology

midwife for preceptorship told us that the trust was working with Middlesex University to attain accreditation of the programme towards a master's degree.

- A band 7 development programme was in place which covered management and leadership skills.
- Developmental clinical workshops were in place for midwife support workers (MSWs). Sessions included: clinical observations and the role of the MSW, temperature control of the newborn and NEWS, the MSW's role in obstetrics emergencies, communication and conduct, newborn blood spot testing, and infant feeding. A handbook that incorporated best practice principles, minimum skills expectations and assessment framework was expected to be completed within 3 months.
- In addition, the trust, in partnership with Thames University, had bought into the Apprentice Programme. This programme entails technical knowledge and real practical experience along with functional and personal skills required in the workplace. The framework contributes towards addressing the skills gaps identified in the Skills for Health Assessment in 2011. At the end of this programme; it is anticipated that the MSW/HCA (Apprentice) will be able to undertake the full range of duties in the range and circumstances appropriate to their role confidently and competently to the standard set by the trust.
- The head of midwifery told us about the 'Great Expectations' project which included a values and behaviours assessment.
- The trust provided data showing that the appraisal rate for midwives and medical staff was 60%.
- We were told that eight hospital-based and two community midwives were qualified in newborn and infant physical examination (NIPE). This contributed to babies receiving timely examination after birth meaning that women were discharged home without undue wait for a paediatric review. Four midwives each year were supported to undertake the NIPE course.
- The Royal College of Anaesthetists (2011) recommended that practitioners, who undertake recovery duties post-surgery, must meet specific criteria in achieving their competencies. We saw documentary evidence that 40% of midwives had attended training. We were told that one midwife with high dependency training was on duty each shift.

- Midwives rotated throughout the service which meant that they were competent to work in all areas in times of escalation.
- The function of statutory supervision of midwives is to ensure that safe and high quality midwifery care is provided to women. The NMC sets the rules and standards for the statutory supervision of midwives. Supervisors of midwives (SoMs) were a source of professional advice on all midwifery matters and were accountable to the local supervising authority midwifery officer (LSAMO) for all supervisory activities.
- The NMC Midwives Rules and Standards (2012) require a ratio of one SoM for 15 midwives. We saw that the SoM ratio was 1:15 which confirmed that there were enough SoMs to support midwifery practice, identify shortfalls and investigate instances of poor practice.
- Midwives reported having access to and support from a SoM 24 hours a day seven days a week and knew how to contact the on-call SoM.
- The service was consistently rated as good for junior doctors training by the RCOG. The team felt that the good working relationships amongst consultants contributed to this. Trainees were given a degree of autonomy and training was delivered on the mentorship model to promote consistency. Junior doctors reported very positive feedback on training and the support they received from the obstetrics and gynaecology consultant team. They found the consultants approachable and reported good relationships with the midwives.

Multidisciplinary working

- We saw evidence of and witnessed that the multi-disciplinary teams were well established on an ethos of mutual respect and recognition of roles. All staff on the delivery suite wore the same coloured scrubs which made it difficult to identify roles.
- A multidisciplinary handover took place twice a day on the delivery suite. The handover used an SBAR (Situation-Background-Assessment-Recommendation) handover sheet and included an overview of all maternity and gynaecology patients. We observed that the 8am handover on delivery suite was concise and efficient. However, there was no representation from neonatal services. We were assured that whilst

Maternity and gynaecology

paediatricians did not attend the handover there were well established communication links between the two disciplines. We also observed coordinated care between obstetrics and the emergency department.

- We saw that handover was followed by a multidisciplinary review of CTGs led by the delivery suite lead consultant from the previous 24 hours. This was an opportunity for discussion and learning. Following the teaching session, a medical ward round took place which the labour ward coordinator attended. A multidisciplinary team teaching session also took place each Friday morning.
- Ward rounds occurred twice daily on the delivery suite and included information on outliers within the service, for example we witnessed an update on a pregnant woman who was under the care of the surgeons.
- Communication with community maternity teams was efficient. In the community we were told of effective multidisciplinary team work between community midwives, health visitors, GPs and social services.
- The gynaecology ward and EGU informed the antenatal clinic if a woman had suffered a pregnancy loss. The clinic informed the community midwives and GPs by email and any ongoing appointments were cancelled.
- We were told of multidisciplinary links with external trusts. For example, the trust was a member of the North East London Maternity and Newborn Clinical Network which enabled the trust to develop shared policies to ensure consistency of quality across the region.

Seven-day services

- Access to medical support was available seven days a week.
- Triage was available over a 24 hour period.
- Community midwives were on call over a 24 hour period to facilitate home births.

Access to information

- Trust intranet and e-mail systems were available to staff which enabled them to keep pace with changes and developments elsewhere in the trust, and access guides, policies and procedures to assist in their specific role. Harmonisation of all policies and guidelines was ongoing and staff could readily see the status of individual guidelines.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw that the procedure of consent was reviewed prior to surgical procedures which was good practice.
- There was 78% compliance with Mental Capacity Act 2005 training and Deprivation of Liberty Safeguards training compliance.
- We spoke with staff who were able to tell us how the Mental Capacity Act and Deprivation of Liberty Safeguards were applied in practice.

Are maternity and gynaecology services caring?

Good



We rated caring as good because:

- We observed that women were treated with kindness, dignity and respect by midwives and medical staff.
- Feedback from patients and those close to them was positive. Patients told us that they felt safe. Staff treated patients with dignity, respect and kindness during all interactions and patient-staff relationships were 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.

Compassionate care

- Maternity services were added to the NHS Friends and Family Test (FFT) in October 2013. In March 2016 a high percentage of patients recommended the antenatal services, postnatal ward and birth services. The scores were similar to the England average:
 - 85% of women would recommend the antenatal service
 - 90% of women would recommend the delivery suite
 - 87% of women would recommend the postnatal
 - 100% of women would recommend the postnatal community service

Maternity and gynaecology

- The CQC maternity survey of December 2015 surveyed women who gave birth in February 2015. A total of 325 women across the trust returned a completed questionnaire. It showed that most outcomes were worse than the national average. The trust scored about the same as other trusts' in three areas:
 - Partner involvement and length of time partner could stay
 - Length of stay
 - Cleanliness of ward, bathrooms and toilets.
- We witnessed interactions between staff and women and observed that staff treated women with courtesy and respect.
- Patients told the trust that community midwives did not always listen and there was not enough time at appointments. Managers said this would be addressed as part of TST and planned to add an extra appointment for birth planning which would take place at the patient's home.
- One patient attending the antenatal clinic told us that she had never had a bad experience at Whipps Cross; she felt listened to and had experienced excellent care.
- Patients on Lilac the Birth Centre told us they felt well supported throughout labour and felt that the midwives had listened to them. One reported that she felt that she had had a better birth experience than her sister who had recently birthed in the consultant led delivery suite. She said she felt that this was because the midwives on Lilac Birth Centre were less hurried.
- On Rowan ward we spoke to two gynaecological patients who reported that they had no concerns regarding the care that they had received.

Understanding and involvement of patients and those close to them

- Women told us that they felt included in their care and felt supported to make informed decisions.
- Partners were not allowed in the theatre until the patient was prepared for surgery and draped. The resuscitaire was not in sight of the patient meaning that if her baby required attention at birth, she could not see what was happening.
- Partners of maternity patients described feeling involved in the care provided.

Emotional support

- Bereavement support was offered a specialist midwife. Memory boxes were provided to parents who had suffered a pregnancy loss. Chaplaincy support was available with access to all religions.
- We had concerns around the emotional support offered to women on Rowan ward suffering pregnancy loss. Whilst we were assured that women are always cared for by a Registered Nurse we could not attain assurance that the nurse had undergone additional training to be able to offer emotional support.

Are maternity and gynaecology services responsive?

Good



We rated responsive as good because:

- Patients' individual needs and preferences were mostly considered when planning and delivering services.
- The maternity service was flexible and provided choice and continuity of care.
- The individual care needs of women at each stage of their pregnancy were acknowledged and acted on as far as possible. There were arrangements in place to support people with particular needs.
- Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, they were investigated and responded to appropriately.

However:

- Only 50.5% of women were seen by a midwife by 10 weeks of pregnancy in between April and June 2016.
- Gynaecology patients were not always cared for in a designated bay.
- A midwife was not always available to answer calls in triage.

Service planning and delivery to meet the needs of local people

- Women could access the maternity services via their GP or by contacting the community midwives directly. All booking appointments were done in a booking clinic at Whipps Cross hospital which meant all women were not able to access this part of the pathway close to home.

Maternity and gynaecology

- Post-natal follow up care was arranged as part of the discharge process with community midwives and, where necessary, doctors. The red book was issued on transfer to the postnatal ward and facilitated on-going care and monitoring of the baby until five years of age.
- There were only facilities for relatives or partners to stay in the bereavement suite on delivery suite.

Access and flow:

Maternity

- The maternity unit had closed once between April 2015 and May 2016.
- Women could access the maternity service via their GP or by direct referral. NICE guidance recommends that women are seen by 10 weeks of pregnancy so that the early screening for Down's Syndrome, which must be completed by the 13 weeks and six days of pregnancy, can be arranged in a timely manner. We saw on the maternity dashboard that 50.5% of women were seen by a midwife by 10 weeks of pregnancy in between April and June 2016.
- The antenatal clinic had introduced numbered tickets which had improved flow. A barrier had also been introduced in front of the reception desks, giving people privacy when speaking to receptionists. Patients told us that this made the queuing system clear. Coloured lines were used to direct patients to parts of the clinic, for example following a red line took patients to the scan rooms.
- A patient told us that she had attended clinic on the wrong day but staff saw her anyway and gave 'great explanations'.
- The day assessment unit (DAU) had five beds and provided an assessment service to women over 20 weeks of pregnancy from 8am to 8pm Monday to Friday, 8am to 3pm on Saturdays and 8am to 3pm on Sundays on an appointment basis. Women could be referred to the DAU by community midwives, GPs, or they could self-refer. Day care was available for women with concerns such as hyperemesis (excessive sickness in pregnancy) and reduced fetal movements. The DAU was staffed by two midwives and a support worker. Medical cover was provided by an obstetric registrar.
- There was a dedicated two bed triage unit where women with urgent complaints could be reviewed and assessed. Triage saw an average of 24 women each 24 hour period. Women were provided with the telephone number for triage and a senior midwife was always on duty in triage to provide advice. All telephone triage was conducted through and by the triage area. This was a point of concern as the triage area is staffed by one midwife. Calls were initially fielded by a receptionist who then liaised with the midwife and relayed the information back to the woman. NICE Intrapartum (2014) 1.3.5 states 'Consider an early assessment of labour by telephone triage provided by a dedicated triage midwife for all women'.
- Five birth rooms, two with birth pools, were located on Lilac Birth Centre which was situated next to DAU. Patients had to pass through DAU to reach the birth centre. Staff told us that this was not ideal because the high level of activity on DAU interrupted the peaceful environment of the birth centre. We saw that the birth rooms offered specialist equipment such as beans bags and birthing balls to promote the comfort of women in labour.
- The delivery suite had 17 delivery rooms, two high dependency rooms, two obstetric theatres and three recovery beds.
- Elective caesarean section lists ran three mornings a week in a dedicated theatre. There were typically three operations on each list. Patients attended a weekly preoperative assessment clinic the week before surgery and were admitted to the delivery suite at 7am on the morning of their operation. However, we noted that some patients were seen up to two weeks in advance of the planned date and others were occasionally missed.
- Patients stayed in recovery for up to four hours before transfer to the postnatal ward and partners were able to stay during this time.
- An enhanced recovery process was in place for women having elective caesarean sections. This involved early ambulation and a one night stay in hospital.
- A postnatal improvement project led by a specialist registrar and a midwife had improved the flow through the maternity unit. The project focussed on the patient's pathway on the postnatal ward, improving the discharge process and information sharing.
- A bay on Mulberry Ward had been refurbished as a postnatal lounge. This had comfortable seating and information leaflets for patients to take away. We saw that group talks were provided for women going home from the postnatal ward. This helped flow because beds were vacated efficiently preventing a back log of women waiting for beds on delivery suite.

Maternity and gynaecology

- A discharge clerk managed the discharge process. Midwives carried out postnatal checks on mothers and babies and completed records. The discharge clerk arranged the paediatric check, which was carried out in a baby clinic by the paediatricians on Mulberry Ward, and ensured take home drugs were prescribed. She also checked that addresses and contact numbers were correct and printed discharge summaries for GPs, child health and the community midwife. Notification of discharges was collected by a community midwife daily who signed to confirm collection. Discharge summaries for patients living outside of the Whipps Cross area were faxed. The trust was in the process of setting up secure NHS email accounts to facilitate electronic discharges.
- A pack including a booklet called 'Going home: our guide to postnatal care at home' containing information, telephone numbers, the complaints process, a number for interpreters if needed, information on breastfeeding support in community; a leaflet on 'caring for your baby at night' and CCG booklet on common diseases in childhood, was given to women on discharge. Additionally the discharge summary, a set of postnatal notes and a breastfeeding assessment form were provided in the pack for the community midwife's use.
- Community midwives referred babies requiring paediatric review for jaundice or weight loss to the paediatric assessment unit. The community teams did have three bilirubinometers to measure the level of jaundice for babies at home but these had been relocated to the postnatal ward.
- We noted that quarterly bed occupancy was 83% to 97% between June 2015 and May 2016. This was greater than the England average of 62%. This indicated that women were having shorter lengths of stay in hospital in comparison to the other trusts.
- The ward manager told us that as it was not safe to have six post-operative patients in one bay, gynaecology patients were spread between all bays on the ward. If patients were in hospital longer than three days, they would try to move them to Pearl. When we asked the shift leader if there were other gynaecology patients elsewhere in the ward; she was unaware of any and told us she 'would have to look in the system'.
- The gynaecology ward had outliers (patients who are not being nursed in a specialist area for their particular condition), which impacted on the care provided to women with gynaecological conditions because beds were occupied with patients with medical conditions. Gynaecology patients were admitted to another ward if gynaecology was full. This meant women were nursed by staff who were not competent in nursing patients with gynaecological conditions.
- The emergency gynaecology unit (EGU) offered appointments between 8am and 8pm weekday and 9am to 1pm at weekends. Referrals for investigation and treatment for bleeding in early pregnancy were accepted from midwives, GPs and the emergency department. On average 18 appointments were available in the morning in and 11 in the afternoons. A consultant clinic and a blood test clinic also ran daily. Women could not self-refer to the EGU. We saw a patient who arrived unannounced was advised to go to accident and emergency for review.
- We saw that 65.75% of patients who required admission were admitted within 18 weeks of referral from April 2015 to March 2016 compared to the trust target of 95%. A total of 312 breaches of the 18 week referral to treatment (RTT) and six breaches of the 52 week RTT were recorded on the Gynae Network Scorecard.
- The two week RTT for cancer patients was 95.7% compared to the trust target of 93% between April 2015 and March 2016.
- The trust provided us with information that showed 54 operations were cancelled on the day of surgery between April 2015 and March 2016.
- Consultant led colposcopy was offered on an outpatient basis. Whipps Cross were not meeting NHS England targets:
 - 88% of patients with a moderate to severe abnormal smear test results had a biopsy compared to the target of 95%
 - 87% of patients were told their result within four weeks of attendance compared to the target of 90%

Access and flow: Gynaecology

- There was 60:40 split between gynaecology day case and inpatient activity.
- Gynaecology patients were cared for on Rowan Ward, a female mixed surgical and gynaecology ward. We were told that a six bedded bay, Pearl, was ring-fenced for gynaecology patients. However we saw that gynaecology patients were not in this bay at the time of our inspection: two gynaecology patients were in Pearl bay but another two gynaecology patients were elsewhere on the ward.

Maternity and gynaecology

- 95.5% of patients were told their result within eight weeks of attendance compared to the target of 100%
- 28% of patients received treatment for high grade abnormalities within four weeks of attending clinic compared to the target of 90%

Meeting people's individual needs

- Specialist midwives for diabetes, antenatal and newborn screening, safeguarding, infant feeding, and bereavement who, having successfully completed additional training, gave advice and support to women and midwives. There was a specialist midwifery team for vulnerable women.
- A variety of specialised clinics were offered to support women. Women requiring anaesthetic review and those with breech presentation, diabetes, thyroid disorders and perinatal mental health needs were seen in consultant led clinics. Midwife led clinics were held for women to discuss birth options and VBAC; for vulnerable women; requiring pre-assessment for elective caesarean section; and for women with gestational diabetes. Additionally, women with Type 1 and II diabetes attended a nurse led clinic.
- The consultant midwife led the birth options clinic for women requesting home birth outside of accepted guidelines or if they were tocophobic (fear of childbirth). Risks were assessed and a birth plan was made in discussion with the woman to support her choices.
- A multidisciplinary diabetic clinic supported women with pre-existing diabetes or those who developed gestational diabetes throughout pregnancy. One patient told us 'Staff are very supportive and informative. I've never had to wait more than 15 minutes'
- The weekly Lotus clinic provided care specifically for women who have undergone female genital mutilation (FGM).
- A patient with dyslexia told us that she had been very well supported by the reception staff at the clinic: 'They made sure I knew which appointments were coming up and held me with the letters'
- The consultant midwife told us of the Maternity Mates (doula) pilot project which would provide 18 months support vulnerable women up to 12 weeks after the birth of their baby.
- The service had secured funding for personal health budgets for women who are tocophobic. Once women were approved they would receive £500 towards the cost of alternative therapies to help them achieve a normal birth.
- Telemetry CTG machines were available which meant women were able to be mobile in labour.
- Privacy and dignity was enabled by the use of privacy screens around beds and on the entrance to rooms on delivery suite and in the antenatal clinic.
- There were arrangements in place to support women and babies with additional care needs and to refer them to specialist services. For example, there was an on-site neonatal unit.
- Partners could visit between 8am and 9pm. Other people could visit at fixed times. This enabled new parents to spend private time with their babies. Staff told us that fathers were welcome to stay overnight.
- There was a dedicated bereavement suite located away from the Mulberry wards. This meant that bereaved families did not meet labouring women or those that had babies with them.
- A bereavement specialist midwife provided care and support to women who suffered pregnancy loss at any stage of pregnancy. A cold cot was available which meant that babies could stay longer with parents. Memory boxes were made up for parents who suffered pregnancy loss.
- Counselling was provided to gynaecology and maternity patients by the bereavement midwife.
- We saw evidence that pregnancy remains were treated with dignity, respect and sensitivity. However, apart from the one specifically trained nurse it was difficult to gauge how appropriate support and consent was offered and attained for disposal of the pregnancy remains.
- Postnatal patients told us that call bells were not always answered promptly; on the morning of our inspection one patient had waited 15 minutes for her bell to be answered.
- Supervisors of Midwives (SoMs) were available to help midwives provide safe care of the mother, baby and her family. SoMs are experienced midwives with additional training and education which enabled them to help midwives provide the best quality midwifery care. They made sure that the care received met women's needs.
- We saw that there was an interpreter service available by telephone.

Maternity and gynaecology

- We highlighted through interrogation of the electronic incident reporting system that the service experienced problems with attendance of translators. The senior management team told us that requests for interpretation services were processed by maternity administrators and managed centrally at Newham University Hospital. They acknowledged that there were some issues with availability of some languages. Managers were aware of the challenge that this presented to frontline staff and said staff could use language line if needed.
- We saw a variety of patient information leaflets available for both maternity and gynaecology patients. For maternity patients, handheld notes were kept in a wallet which was colourfully printed with important advice regarding both the mother's and her baby's health. This ensured that key messages such as monitoring babies' movements became second nature to patients because they carried the wallet with them.
- One gynaecology patient told us that she was given written information that was not specific to her operation. She was not directed to any support groups which she would have liked.
- On Rowan ward, patients told us there was a high level of noise; other patients used mobile phones on loud speaker which was managed by staff. Patients on Mulberry ward also had the same complaint.

Learning from complaints and concerns

- Complaints were managed in line with trust policy. If a woman or relative wanted to make informal complaints, they would be directed to the midwife or nurse in charge. Staff would direct patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with concerns. PALS used a closure form for informal complaints so that themes could be identified. Patients would be advised to make a formal complaint if their concerns were not resolved.
- We saw a trust information leaflet for patients and those close to them informing them of how to raise concerns or make complaints. Complaints were reviewed weekly and distributed to responsible officers for investigation and response within 25 days.
- The head of midwifery told us that complaints had just started to be shared with staff.
- Information from the trust indicated that there had been 80 maternity and 34 gynaecology formal complaints made between April 2015 and June 2016.

We saw evidence that 14 complaints had been received between March and May this year. Six of the complaints pertained to treatment within Delivery Suite these were broken down into:

- Complication of treatment not recognised (1)
 - Inadequate medical care (1)
 - Inadequate nursing/midwifery care (2)
 - Staff Conduct (poor attitude to a visitor) (1)
 - Verbal poor communication (1)
- We discussed learning from complaints with the head of midwifery who told us that care issues and staff attitude were common themes and that historically poor staff attitude was a feature of complaints from Mulberry ward. They also felt that the incidents which we reviewed relating to disrespectful or inappropriate language may be related to the fact that Bart's Health ran a campaign offering £25 reward to staff who input incidents..

Are maternity and gynaecology services well-led?

Good

We rated well-led as good because:

- There was a clear maternity vision and strategy.
- There were good clinical multidisciplinary working relationships. Leaders were described as visible and approachable.
- Service users participated in quality improvements.

However:

- There was some evidence that cultural and ethnic differences had an impact on how staff treated each other.

Leadership of service

- The service was led by a triumvirate that included the head of midwifery, clinical director and the service manager. We observed that this was cohesive and functional triumvirate that shared good relationships. The senior team were proud that there was willingness amongst the staff to lead on improvements and quality.
- The HoM was supported by a consultant midwife, three matrons, a risk and governance midwife a practice development midwife, and a matron for gynaecology.

Maternity and gynaecology

- Midwifery staff spoke positively about matrons at departmental level and their support in general. Staff said that senior managers were visible, approachable and supportive. This meant that they were easily accessible to staff.
- We saw good examples of leadership; in particular the practice development midwife and the lead consultant on delivery suite displayed outstanding leadership.
- Supervisors of midwives led by example and walked the wards to offer support and guidance to midwives.
- We saw that the HoM through the Director of Midwifery had direct access to the trust board. This meant that the board could be readily sighted on issues relating to maternity.
- Members of the trust board were not visible at ward level. Staff reported that they were aware that the Chief Executive's weekly newsletter was available on the hospital intranet.

Vision and strategy for this service

- The vision for women using Bart's Health maternity services was centred on supporting the transition from pregnancy to family life with a quality service that is woman and family focussed and reflects local needs and priorities.
- The 'Transforming Services Together' (TST) strategy was aligned with the Maternity Review: Better Births and was driving the vision for service. The aims of TST were to improve care, offer choice and make sustainable change. The strategy included ensuring women see no more than two or three midwives throughout pregnancy who will properly explain the benefits and risks of choices available at every stage; developing a culture that values normality and empowers and values midwives; establishing a sustainable way of resourcing high quality maternity care; and the reduction of unnecessary interventions through promoting midwife led care.
- The Great Expectations Project was launched in the women's service in June 2013. The focus of the project was to improve outcomes for women and families based on an improvement in their actual and perceived experience of the service. Great Expectations provided an education programme to improve clinical, behavioural and leadership skills for maternity staff. The Great Expectations maternity pledge was based around the six Cs (these are that the services are Caring, Compassionate, Competent, Communicative,

Courageous and Committed). The pledge of the project for women accessing maternity service within Bart's Health is that 'every contact counts'. This vision was agreed within the service through an implementation project with all groups of staff.

- The vision and strategy for the gynaecology service was a site redevelopment programme and continued promotion of the specialist endometriosis and uro-gynaecology services which attracted revenue from neighbouring trusts.
- The matron for gynaecological services informed us that one of their key projects was to implement enhanced recovery pathways for post-operative women.

Governance and risk management

- Local leadership reported directly to the clinical academic group (CAG). The triumvirate agreed that obstetrics and gynaecology was well represented.
- Senior leaders had also started attending the overview and scrutiny committee which met bi-monthly.
- A governance manager was in post who led a team with responsibility for patient safety and risk, compliance, audit and guidelines, and complaints.
- The head of midwifery (HoM) and the governance lead reviewed all electronic incident report submissions. These were discussed at a weekly risk meeting and allocated to an incident manager if it was considered that further investigation was required.
- The National Reporting and Learning System (NRLS) template was used to identify serious incidents (SIs) which were reviewed by a multidisciplinary panel and a three day report produced. SIs were uploaded to STEIS twice a week and were reviewed at the serious incident, risk management and assurance panel (SIRMAP). A triage process was used to decide whether an internal investigation or an external root cause analysis (RCA) was required. Staff from the Royal London site sat on investigation panels or external reviews would be commissioned to undertake investigations.
- Following investigation or RCA the SI was discussed by the SIRMAP who challenged findings, made a judgement and decided on recommendations and actions.
- Action plans were tracked and kept under review at the monthly local risk management group and clinical governance meetings which reported to the cross site quarterly Maternity Quality Assurance and Safety Committee.

Maternity and gynaecology

- We reviewed the minutes of the Maternity Quality Assurance and Safety Committee for March 2016 and saw that the meetings followed a standing agenda. Issues were identified and actions were planned and reviewed.
- Staff told us that they received feedback in various ways including at safety brief during handover weekly meetings and the quarterly governance newsletter that summarised incidents, complaints and claims and trends analysis and learning. To share learning from SIs, the trust told us that feedback “sharing the learning” slides that the trust had sanctioned were sent out.
- The monthly multidisciplinary cross site perinatal board discussed adverse events in order to identify the causes so that steps could be taken to prevent recurrence. There was also a cross site gynaecology board.
- The HoM told us their biggest concern was the embedding governance processes and particularly the sharing of learning with staff. They anticipated that the trajectory for embedding would be three to four months. Furthermore, the benchmarking exercise against the Morecambe Bay Report demonstrated the service needed a forum to share thematic analysis with staff groups.
- The maternity and gynaecology risk register was reviewed monthly at the risk management meeting. We saw that the risk register contained four risks; all risks related to maternity and were: access to store room on Lilac/Magnolia ward via milk kitchen; community midwives booking centre; inadequate maternity facilities; removal of dedicated Carillion security/reception from maternity services
- We saw that risks were RAG rated, that progress was noted, that the risk register was discussed at the monthly obstetrics and gynaecology governance group meeting and reported on a quarterly basis to the divisional quality and safety board.
- The corporate risk register had two risks related to maternity: the inability to recruit sonographers and the lack of obstetric consultant presence on the delivery suite.
- The RCOG Good Practice No. 7 (Maternity Dashboard: Clinical Performance and Governance Score Card) guideline recommends the use of a maternity dashboard. The Maternity Dashboard serves as a clinical performance and governance score card to monitor the implementation of the principles of clinical governance

in a maternity service. This may help to identify patient safety issues in advance so that timely and appropriate action can be instituted to ensure woman-centred, high-quality and safe maternity care.

- The service introduced a Maternity Dashboard across Barts Health Care with clear safety goals. This had been developed with the North East London Maternity Network. Each site had a local dashboard which was then merged and presented at the cross site Perinatal Health Board. An interface with CCGs enables benchmarking against other London trusts and nationally. The dashboard was emailed to staff as well as being displayed in clinical areas.
- We saw evidence that the service utilised quality data to monitor the safety and effectiveness of the service. An example of this was the establishment of a breech clinic as a consequence of a rise in emergency caesarean sections as a result of undiagnosed breech presentation in labour.
- A delivery suite forum met monthly to identify areas of good practice and new evidence based practice.
- Guidelines were kept under review by the governance manager. Guidelines were developed by the guideline committee and ratified at the weekly risk meeting.

Culture within the service

- From our observations and discussion with staff we saw a strong commitment to meeting the needs and experiences of people using the service.
- The Deputy Director of Midwifery told us they were proud of the working relationships between consultants and midwives. Following work with the culture team who did a ‘walk in your shoes’ exercise they felt that working relationships between staff had improved. However we witnessed a disrespectful interaction between midwifery staff on Mulberry Ward.
- A top down management approach caused discontent in community teams. The staff did not feel listened to. The Deputy Director of Midwifery said the community midwives were a challenging group of individuals who often displayed challenging and defensive behaviours. They were confident that the community teams recognised that change was needed and that a “bottom-up approach is now beginning to gather momentum”.
- The consultant midwife had witnessed a change in culture over the last two years, attributed to more visible and proactive leadership that engaged more with staff.

Maternity and gynaecology

- Staff described the maternity unit as warm and friendly. Patients who had used the service before told us 'it was much better this time'.
- On Rowan ward, a patient told us that the sister had approached doctors who were being abrupt with junior nurses. Staff told us that a 'bad apple' had left and attitudes had changed, one said 'the whole atmosphere has lifted'.
- 'Listening into Action' (LIA) was developed as a new way of working to engage with staff in different way. LIA was designed to empower staff at all levels by identifying and driving through the changes and improvements they want to see.
- We saw that a 'Smile to care campaign' was ongoing and staff were photographed with a poster with their name and what they enjoyed about their role on.
- A staff wellbeing fair had been held at Whipps Cross.







Public and staff engagement

- There were two patient experience initiatives: the maternity service liaison committee which met bimonthly and Mums2 Mums which was a group of service users who visited the postnatal ward to elicit views.
- The Great Expectations project had an engagement and women's experience plan for 2016/17. Listening to patients was used to improve practice. For example developing care bundles, values and behaviours, leadership masterclasses and development programmes

Innovation, improvement and sustainability

- The maternity service was part of a trust-wide improvement strategy, 'Transforming Services Together'.
- There was a pilot project called 'Maternity Mates' to support vulnerable women up to 12 weeks postnatal.
- The service secured funding for personal health budgets for women who are tocophobic. Once women are approved they will receive £500 towards the cost of alternative therapies to help them achieve a normal birth.

Services for children and young people

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

Information about the service

Whipps Cross Hospital provides a range of health services for babies, children and young people. The general paediatric ward has 27 inpatient beds across three distinct clinical areas: a general acute ward, a surgical day unit and a medical day unit. The ward provides care to children with a range of general and specialist medical and surgical conditions including cystic fibrosis, sickle cell disease and malignant conditions.

The neonatal unit has 18 cot spaces and includes up to two temporary intensive care spaces with a maximum of 24 hours ventilation intervention before being retrieved. There are five or six spaces for babies requiring high dependency care with the remaining beds designated as special care. A stand-alone children's and young people's outpatient department provides a range of specialist clinics such as those for children with diabetes.

Between January 2015 and December 2015, children's services treated or provided care for 3,429 patients.

During the inspection, we spoke with 14 parents and their children as well as over 48 members of staff including doctors and nurses of all grades, therapies staff, healthcare assistants, clinical and non-clinical managers, clinical leads, clinical directors and administrative staff in all clinical domains.

Summary of findings

We rated this service overall as good because:

- Most staff were aware of the trust vision and values and we saw that staff members had been provided with information on trust developments that had been cascaded down through regular trust emailed newsletters and reiterated from their line managers. There were governance arrangements in place within children's services for which a range of healthcare professionals assumed ownership.
- Staff members demonstrated and were encouraged to adopt an open and transparent culture about incident reporting with no fears of retribution. A culture of optimising patient safety was apparent amongst nursing and medical staff alike. Staff understood their roles and responsibilities in reporting incidents and described how they learnt from incidents.
- Standards of infection prevention and control and auditing processes were in place and senior staff were held accountable when practice was found to be substandard.
- Patients were safeguarded from the risk of abuse and we saw that staff fully understood how to activate as necessary the trust's local safeguarding policies and could describe national best practice guidance. Staff demonstrated a systematic approach to the assessment, planning and delivery of individualised care to children and their families.

Services for children and young people

- We saw that multidisciplinary team working was embedded in practice and that it enhanced the ability of the clinical teams to work collaboratively in the enhancement of care delivery to children and young people and babies.
- Children's services participated in a range of local and national audits including clinical audits and other monitoring activities such as a complete review of adolescent services. Accurate and up-to-date information about effectiveness of care delivery was shared internally and externally across the trust and was understood by staff. Information from local and national audit programmes such as that for diabetes was used to improve care and treatment and children's healthcare outcomes.
- When young people were scheduled to move between children's services and adult services their transition needs were assessed early, with the involvement of all necessary staff, teams and services. Discharge planning reflected children's individual needs, circumstances, ongoing care arrangements and expected outcomes.

However:

- Nursing staff levels did not always meet national standards in the majority of clinical areas including the neonatal unit. Staffing issues for nurses were on the service risk register and risk to patients was controlled through the use of bank and agency staff. Although the cot occupancy of the neonatal unit was lower than normal during the period of the inspection, capacity within the neonatal unit meant that the number of consultants and junior doctors employed was not sufficient to meet the needs of the unit. There was an over reliance on the good will of a small number of doctors to work additional hours through the bank or through the employment of agency doctors. The availability of specialist medical staff and nursing staff was inconsistent and a number of senior staff raised this as a safety concern. However, although nurse staffing levels had been a challenge for an extended period, a rolling programme of recruitment was in place.
- The environment in which children were cared for within Acorn, the general paediatric ward, was in the

main appropriate, although residential accommodation for the parents was basic, consisting of "put you up" camp beds. We saw that facilities for young people were in the process of being improved.

- The physical care environment of the neonatal unit was below expected standards. The general appearance of the neonatal unit was shabby with broken handles and broken equipment and with a poor state of decor throughout. Dark corridors with mobile air conditioning units exacerbated the lack of space although the nursery areas were visibly clean and tidy but tired and dated in appearance.
- Staff acknowledged that the demands on the service were increasingly impacting on the physical infrastructure of the buildings housing children's services. In particular, the neonatal unit where the service had recognised that there were inadequate facilities for both the care of the babies and their parents or carers. The management team recognised the need to improve the physical care infrastructure of children's services over the coming years to ensure that it could continue to meet the needs of the population it served.

Services for children and young people

Are services for children and young people safe?

Requires improvement



We rated safe as requires improvement because:

- Although risks were controlled by the use of bank and agency nursing and medical staff, capacity within the neonatal unit and Acorn Ward was lower than average with the number of consultants and junior doctors and trained children's nurses employed not always being sufficient to fully meet the needs of patients.
- Sustainability of staff medical cover was at risk in the long term as there was a reliance on the small number of doctors and nurses to work additional hours via the bank, augmented with frequent use of agency staff.
- The environment in which children and neonates was cared for was, in the main, provided in appropriate premises although the care environment of the neonatal unit was out-dated, tired and in need of refurbishment.

However:

- Apart from medical staff the uptake of mandatory training by the staff was good and met nationally accepted standards.
- Standards of infection prevention and control were generally good.
- Staff demonstrated an open and transparent culture about incident reporting. A culture of safeguarding patient safety was transparent amongst nursing, allied health care professionals and medical staff alike. Staff understood their roles and responsibilities in reporting incidents and described how they learnt from incidents.
- Patients were safeguarded from the risk of abuse; staff were familiar with the trust's local safeguarding policies and was able to describe national best practice guidance.

Incidents

- No never events had been reported by the hospital for the children's and young people's service in the period

between August 2015 and July 2016. A never event is a wholly preventable incident, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level.

- Between August 2015 and July 2016 there were three serious incidents reported by the service to the strategic executive information system (STEIS). Two incidents were recorded as maternity/obstetric incidents. One incident related to an unexpected neonatal death following a normal delivery. The other related to a woman with maternal shock and sepsis whose baby was born very poorly and later died. The final incident involved a treatment delay resulting in the retrieval of a child to a tertiary children's unit elsewhere in London.
- Between April 2015 and April 2016 the trust reported to the Patient Safety Thermometer three pressure ulcers, three falls with harm and two catheter acquired urinary tract infections. The Patient Safety Thermometer was developed for the NHS as a point of care survey instrument and its design provides safety checks on harms that might be perpetrated on patients that can be used alongside other measures of harm to measure progress by a hospital in providing a care environment which is harm free.
- Learning from incidents was shared with staff through monthly clinical risk meetings and through the paediatric newsletter which was emailed to staff members each month and gave details of any learning from incidents. Staff we spoke with told us that they received and read the newsletters. Introduced by the assistant director of nursing for children's services the newsletter included trends from incidents, as well as describing the lessons that had been learnt and actions that staff should consider to help reduce the risk to patients. The practice educator we spoke with explained to us that there had been two cases of reported pressure ulcers in children. The first concerned a disabled wheel chair bound child where the ulcer was caused by repetitive foot banging and in the second case the child arrived on the ward with an existing ulcer. The practice development nurse acknowledged that the two cases had been overlooked by poor initial assessments of the children on admission. We inspected the admission packs and saw they contained a body

Services for children and young people

map and a wound bundle algorithm and that greater vigilance in initial assessment had led to improved pressure area surveillance since the cases were reported.

- Each member of staff we spoke with was aware of the procedure for submitting an incident report and was confident in doing so. Staff members told us that training in the use of Datix was part of the induction process and student nurses we spoke with on placement within the children's services unit had also been made aware of the reporting system and had observed their mentors using the process. Datix is the patient safety culture, healthcare incidents and risk management software used in many parts of the NHS. This software application allows staff members to report adverse events and near misses and facilitates initial recording through to investigation and subsequent root cause analysis.
- The duty of candour was fully embedded and for all incidents the senior nurse or a consultant met and spoke with parents or guardians. Consultants and nursing staff were well versed in the concept of their responsibilities regarding the duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.. There were local arrangements in place for ensuring that patients and their carers were kept informed of incidents and were provided with the necessary support as well as being kept informed of any investigations and their outcomes.
- The junior doctors we spoke with told us that they felt well supported by the consultants and that they were confident about being able to raise a concern or report an incident via Datix. They all attended the monthly risk meetings where all incidents were discussed and the learning from this was cascaded via email.
- Staff felt that that incident reporting had improved and that the previous stigma of reporting has ceased. We saw that there was a culture of high incident reporting and low harm.
- Staff we spoke with told us that emails were received in relation to incidents and that every two weeks a safety and quality meeting was held to discuss incidents. In addition to these multidisciplinary meeting a hospital-wide serious incident meeting was held weekly. Staff we spoke with on the neonatal unit confirmed that they were able to attend the weekly mortality and morbidity meetings. The paediatric dietitian we spoke with told us that she was confident in the use of Datix and that she attended weekly risk meetings.
- Medical, nursing, allied health professionals and support staff throughout children's services told us that they had been encouraged to report incidents by members of the senior medical and nursing teams. To help reduce the natural concerns by staff of raising an incident without fear of recrimination, one of the senior nurses had used a sweets jar and had filled it with a sweet for every incident reported over a three-month period to demystify reporting.
- Staff we spoke with in the children's outpatient department told us that they were fully conversant with incident reporting processes and that they were happy to report an incident without fear of retribution, in their words "a sea change from the last CQC inspection".
- The staff told us that the daily safety huddles introduced across children's services were highly valued as a way of monitoring the acuity and dependency of sick children and importantly reviewing any incidents arising since the last huddle. These 'patient safety huddles' had been introduced to help reduce patient harm throughout children's services. The huddles were led by the most senior clinician and took place at a regular time each day for 10–15 minutes. They were configured to provide a non-judgemental venue for team members to develop confidence to speak up and jointly act on any safety concerns they had. The huddles had become a method for the clinical teams to continually learn and improve. The safety huddle was held at 11am each day and we saw that it covered each area of children's services and at the meeting we attended, acuity and dependency of children was discussed. Additionally, staffing and capacity, DNAR and end of life care and safeguarding issues were discussed. Members of the executive team for children's services frequently attended the huddles.

Cleanliness, infection control and hygiene

- The head of infection control told us that there were link infection control nurses in each of the designated areas of children's services and the staff we spoke with knew the name of the infection prevention and control (IPC) lead nurse.

Services for children and young people

- We saw that there were IPC meetings every two months and that IPC mandatory updating was 100% compliant.
- We saw that information control information was visible to both staff and visitors to the clinical areas.
- We saw evidence of regular hand hygiene audits and inspected the audit completed in June 2016 which was 100% compliant and also saw that IPC information was cascaded to staff via the ward dashboards.
- During our inspection there was an outbreak of MRSA within the neonatal unit and we noted that although the positive MRSA culture report was received during the night shift the babies concerned were not separated from non-infected babies until the following morning therefore exposing babies to risk longer than necessary.
- The cleaning duties had been tendered out to a private company and we observed the domestic staff at work undertaking damp dusting. We saw that the waste management met national guidelines and that national colour coding was in use for mop heads and other cleaning equipment. Domestic staff we spoke with told us that they followed daily cleaning schedules.
- Most of the clinical areas were visibly clean and tidy including the nursery areas of the neonatal unit. However we saw that the overall decor of the neonatal unit was tired and dated in appearance. We saw that the air conditioning unit in the ceiling in one of the nursery rooms was not clean. The general appearance of the neonatal unit was shabby with broken handles and broken equipment. The dark corridors with mobile air conditioning units made the whole of the neonatal unit feel very cramped.
- We noted that there were three dirty incubators in the corridor of the neonatal unit with cards showing that they had not been cleaned for 4-6 days, although the housekeeper we spoke with told us that they had only been left out uncleaned overnight suggesting that the babies may have been in the incubators longer than recommended IPC rules for cleaning.
- A housekeeper we spoke with told us that there were storage space issues within the neonatal unit but that she was aware of her duties regarding other IPC duties including fridge temperature recordings etc.
- The clinical areas had regular housekeeping cleaners and we saw that they were perceived to be part of the ward teams.
- The junior doctors we spoke with told us that they thought the clinical areas were very clean and that the domestic staff did a good job.
- Parents we spoke with told us that they saw nurses and doctors washing their hands and wearing appropriate personal protective equipment (PPE). Parents commented on the cleanliness of the clinical areas.
- We saw that there was guidance available to staff on the cleaning of patient equipment and we saw staff using PPE. We examined a range of patient equipment including two blood pressure cuffs and two commodes and saw that they were clean. We saw staff washing their hands before and after patient contact following national guidelines. We saw that dirty utility rooms were fully clean and well maintained.
- The infection control staff we interviewed in the outpatient department told us that there were arrangements in place for ensuring that toys and play equipment was appropriately decontaminated between use and that toys were cleaned after every clinic. Additionally, a volunteer attended the department once per week to undertake a full maintenance of the toy library.
- Hand wash basins were available in each of the clinical areas and we observed visitors using these facilities. We also saw parents, visitors and staff members frequently using the hand sanitisers.
- We observed staff complying with the trust's policies for infection prevention and control. This included wearing personal protective equipment, such as aprons and gloves, following the 'bare below the elbows' policy and frequently decontaminating hands both before and after patient contacts.

Environment and equipment

- Children's services at Whipps Cross Hospital consisted of Acorn ward, the neonatal unit and the outpatient department. Acorn ward had three distinct clinical areas, a general acute ward, a surgical day unit and a medical day unit. The ward areas were quite spacious

Services for children and young people

but somewhat dark especially as during our visit many of the internal lights were not functioning but were repaired during our visit. The care environment was quite pleasant but a little dated.

- The neonatal unit had 18 cot spaces including one to two intensive care (ITU) spaces with a maximum of 24 hours ventilation intervention before being retrieved. We saw that there were five to six spaces for high dependency babies receiving CPAP (continuous positive airway pressure, which is a treatment that uses mild air pressure to keep a baby's airways open), with the remaining cots used for special care.
- We saw that the neonatal unit has only one toilet for all relatives and visitors. The unit did have a breast feeding expressing room which was small and lacking in any decoration. However we were told that parents could use breast pumps for a small deposit. There was a parents' sitting room and some toys for siblings but it was dull and uninviting. Staff told us that siblings could only visit out of school hours and that any child appearing in uniform during school hours would be referred to the school concerned.
- There was 24-hour visiting for parents in the neonatal unit but although we were told that there was a welcome pack we were not shown a copy, it was in the process of being updated. There was a parents' kitchen without a lock and no facilities to label parental food.
- Parental accommodation within the neonatal unit consisted of one single and one double en suite room but we noted that the ambiance was dull and sterile and lacked any decoration to make it welcoming.
- The general appearance of the neonatal unit was shabby with broken handles and broken equipment and with a poor state of decor throughout. Dark corridors with mobile air conditioning units made the whole place look cramped.
- The nursery areas were visibly clean and tidy but tired and dated in appearance. We saw that the air conditioning unit in the ceiling in nursery room 1 was not clean. The neonatal unit staff told us that many parents felt daunted by the poor physical structure of the neonatal unit but that after a few days they settled in and many opted to stay when offered the chance to transfer to a unit nearer home.
- The outpatient department is a stand-alone department and we saw that it was child friendly with ample supplies of toys and recreational equipment for children to play with.
- Each of the clinical areas where children were inpatients were locked, preventing unauthorised access and monitored by CCTV. Parents/carers and visitors were able to gain access to the clinical areas by using a buzzer system, which was monitored by nursing staff. We saw that members of staff greeted each visitor as they entered each of the clinical areas.
- Information about tailgating was detailed in the ward admission booklet which was given to parents and guardians and which was reinforced by staff members.
- We saw that children's services had a child abduction and absconding policy but this had not been subject to a full scenario rehearsal.
- Children's services had a range of equipment that was cleaned and checked regularly and was sent for routine maintenance. Staff were aware of who to contact or alert if they identified faulty equipment or environmental issues that needed attention.
- We checked all of the resuscitation trolleys throughout the service and each clinical area had resuscitation equipment with emergency drugs, oxygen and echocardiogram machine. Daily checks were documented in every area we visited.
- Senior nurses we spoke with told us that the drug fridges and human milk storage fridges were constantly monitored and our pharmacist specialist advisor observed that the logs had been partially completed and that the temperature variations were within recommended guidelines. We did notice that one of the milk freezers was fully iced up and therefore reduced storage capacity.
- The junior doctors we spoke with told us that some of the equipment within the neonatal unit was old and although still functioning needed updating.
- We saw that the conditions within the neonatal unit were cramped, due to the out-dated design which predated the use of modern technology, made worse through the presence of chairs for visitors and family members.

Medicines

Services for children and young people

- We visited the treatment rooms, storage rooms and medicine preparation areas throughout children's services and treatment rooms were clean and tidy, with no medicines seen lying around unnecessarily.
- To take out (TTO) medicines were stored securely and appropriately in designated cupboards.
- A registered nurse was responsible for the keys to the drug cupboards and lockers and the doors to the room housing medicines were locked.
- Controlled drugs (CDs) were audited on a daily basis by two nurses, with a separate signing sheet. CDs were correctly documented in a register, which was in line with National Institute of Health and Care Excellence (NICE) guidelines.
- We noted that the drug preparation room within Acorn ward had been placed on the risk register as being unfit for purpose. This was because of poor ventilation, inadequate space and poor locking door mechanisms. However, we saw that measures had been implemented to control any potential risks including new door locks. Work had already commenced on building a more fit for purpose drug preparation room and we saw that this work was nearing completion during our inspection
- There were processes for ensuring medications were kept securely. Medication fridges were routinely checked to ensure they were operating correctly in order that medicines were stored in in line with manufacturer recommendations.
- We reviewed four drug charts and saw that all the children's details were appropriately recorded, with the child's weight and allergy status documented. We saw that medications had been prescribed by registered medical practitioners and each chart was found to be legible. We noted that drug monographs had been printed which provided detailed information pertinent to each of the intravenous medications prescribed for various children.
- Staff had access to policies and supporting information, including intravenous drug preparation guidance, British National Formulary (BNF) for Children and pharmacist support.
- Children's services had a dedicated pharmacist available Monday to Friday between 9am and 5pm with on call facilities for other periods and most nursing and

medical staff told us they were happy with the pharmacy service received out of hours during evenings and weekends. They commended the support and advice they received from their paediatric pharmacist.

Records

- We saw that the paper records were stored very securely with a very effective key pad entry system.
- We randomly checked 16 observation records and case-tracked the 16 sets of patient records, and noted that all of them had been completed and were fully up to date. We saw that child safeguarding issues were flagged appropriately.
- We saw that each child had a plan of care and on the neonatal unit we saw evidence of breastfeeding plans in line with UNICEF baby friendly guidelines. The neonatal service at Whipps Cross Hospital was fully accredited by the UNICEF Baby Friendly Initiative.
- We also noted as appropriate that the patient records we reviewed contained up to date pain assessment charts and for example skin integrity assessment charts. We also saw that the observation records had included observations using the paediatric early warning score algorithm (PEWS).
- Nurses received clinical documentation training as part of their induction and ongoing mandatory training.
- Staff we spoke with in the outpatient departments told us that records arrived in the outpatients in a timely fashion.

Safeguarding

- The trust required all staff within children's services to undertake safeguarding children level 1 and safeguarding children level 2 as appropriate with level 3 training for medical and nursing staff and allied health professionals.
- A practice development nurse we spoke to told us that all mandatory training was co-ordinated through 'Wired' which is the trustwide educational software management system. This system is used by many NHS trusts and was developed by Skills for Health, and is designed to help trusts achieve better compliance to mandatory training and identify training needs across the workforce.

Services for children and young people

- We saw that children's services had expended much time and effort in improving uptake and compliance to mandatory training requirements. We inspected the training database during our inspection and saw that compliance to level 3 children's safeguarding was 100% for nursing staff. Data we inspected prior to the inspection showed that compliance by medical staff for level 3 safeguarding was 89%. This was just below the trust's target of 90%.
- The nurses, doctors and allied health care professionals we spoke with told us that each of them had a wired account to monitor their mandatory training and they all thought wired worked well and that it was a good way of ensuring the uptake of mandatory training among the staff of children's services. Staff were given protected time to complete online mandatory training and staff we spoke with, for example a physiotherapist and a paediatric pharmacist, told us that their level three training was up to date. The healthcare assistant (HCA) we spoke with who was employed through the hospital bank system told us that she had received safeguarding training as part of her induction.
- The outpatient staff told us that vulnerable children were flagged within the patient record and that this was updated by the safeguarding team and included domestic violence, learning difficulties and wheelchair users. This information was provided before the clinic commenced to ensure that appropriate provision was offered on the day.
- The safeguarding link nurse we spoke with from the neonatal unit told us that all cases where there were concerns related to consent, abuse etc. would be fully considered at the multidisciplinary team (MDT) meetings. We attended one of these meetings, led by the consultant of the week (the COW) and saw that the safeguarding lead was also present and we noted that individual concerns about babies were discussed. The COW acknowledged that more social worker involvement would be advantageous but recognised that time constraints on social workers made this problematic and therefore social workers did not attend the MDT meetings as a routine. However, where any babies were to be discharged with ongoing concerns then a social worker would attend and the discharge planning meeting would include the infants designated social worker. During MTD meetings we noticed that the situation of teen mothers were debated with reference to future safeguarding issues.
- In all areas of children's services we inspected, staff we spoke with could describe the referral process for alleged or suspected child abuse and knew the names of the lead staff member for safeguarding. Staff members said they were well supported by the safeguarding team and could access them for advice and support on an 'as required' basis.
- The lead nurse for safeguarding that we spoke with told us that she was able to attend the Tavistock Institute, which is a charity which executive coaching and professional development, for on-going and continuing supervision. She told us that all staff were vigilant for female genital mutilation (FGM) and for vaginal reconstructions. The associated Lotus clinic is an FGM clinic which provides specialist social worker support. She told us that the nursing staff were 100% compliant for level 3 safeguarding. She attended the weekly MDT psycho social meetings which addressed the needs of all children with safeguarding concerns including those with disabilities or for example children with needle phobia. The trust listening into action initiative has led to an emphasis on adolescent care and she is currently working with young people to develop a credit card size help sheet for safeguarding information.
- We also saw that the nursing staff had access to flash card packs which had information on a range of clinically related topics including safeguarding information. These 'handy-to-use', pocket-sized memory joggers and reference guides helped the nurses to optimise their care delivery for children. There were close working relations between safeguarding leads and the nursing and medical staff working within children's services.

Mandatory training

- We saw that children's services had expended considerable effort in improving its mandatory training compliance partly through more consistent use of the wired educational database and also through annual appraisal and the activities of the practice education facilitator.
- The trust provided us with data on mandatory and statutory training completion rates for children's services, by staff group, for the 12-month period prior to

Services for children and young people

our inspection. The trust's mandatory and statutory training target was 90% for all areas. The data provided by the trust showed that although the vast majority of nursing, additional clinical and admin staff were meeting the target in the majority of areas, training compliance was variable within the medical staff group. This presents a risk to patient safety if staff do not have the required training.

- Administrative and clinical staff achieved 100% compliance in all relevant mandatory and statutory training which included infection control, safeguarding adults and children (both level 1), dementia awareness, fire safety and information governance.
- Nursing staff met the training target for all mandatory and statutory training aside from medical gas safety training which 74% of nurses had completed. Medical staff and additional clinical staff groups also failed to meet the compliance target with only 66% and 57% of staff completing this training.
- Additional clinic services staff achieved 100% compliance in all but four training areas; medical gas safety (57%), care certificate completion (75%), fire safety (86%) and basic life support (86%).
- The medical and dental staff group had the lowest overall compliance with mandatory and statutory training. Only in 12 out of the required 32 training areas did they comply with the trust's 90% target. This included safeguarding children level 1, safeguarding adults level 1 '4 harms' training, clinical documentation, dementia awareness, early warning systems, nutritional care, privacy and dignity and moving and handling patients. Of medical staff, 89% had completed safeguarding children level 3 which was just marginally below the trust target. Only 79% of medical staff had completed safeguarding children level 2. In some training areas medical staff compliance was very low included moving and handling (inanimate loads) at 50%, basic life support at 56%, blood transfusion and infection control level 3, both at 63%, medical gas safety and infection control levels 1 and 2 both at 66%.
- The nurses we spoke with told us that their career development was discussed at the annual appraisal and that they were confident that the trust was investing in

staff training. They told us that funding was available to help them pursue their careers. They said they were given protected time to complete online mandatory training.

- Children's services had educational notice boards showing strong links with local universities. For example, within the neonatal unit there were notices advertising the availability of neonatal nursing courses.
- The areas of children's services always had nursing students allocated there from local universities and we saw that mentoring arrangements met the NMC standards.
- Agency staff and bank staff received mandatory training.

Assessing and responding to patient risk

- The children's services used the paediatric early warning scoring system (PEWS) to promote the early recognition of deteriorating children. Such early warning tools measure aspects of a sick child's physiological status including systolic blood pressure, capillary refill time, respiratory rate, respiratory effort, transcutaneous oxygen saturation and oxygen therapy. Through PEWS we saw that staff were able to identify children who needed escalation of care. We saw evidence in the patient records and the bedside charts of PEWS monitoring charts for different age groups, namely ages zero to three months, three to 12 months, one to five years, five to 12 years and from 12 years upwards. We saw that the PEW recording charts were completed as appropriate on admission and then at planned frequencies during the patient's stay.
- We looked at completed charts and saw that repeat observations had been taken within the necessary time frame.
- Staff we spoke with told us how they used the PEWS charts and how they matched the score to care recommendations. Staff had knowledge of the appropriate action to be taken if a patient's PEWS was elevated and they reported that medical staff responded within set timescales, which ensured that patients were assessed in a timely manner. Nurses we spoke with also told us that they used SBAR when communicating with other children's services such as the paediatric emergency department. SBAR is the Situation,

Services for children and young people

Background, Assessment and Recommendation Technique. This structured method for communicating critical information contributes to effective escalation and increased child safety.

- We saw that Sepsis Six was being used within children's services following one of the "listening into action initiatives" and we noted several posters advertising this throughout the hospital. The Sepsis Six consist of a bundle of medical therapies designed to reduce the mortality of patients with suspected sepsis.
- The safety huddle which was held at 11am each day covered each area of children's services and where acuity and dependency of children was discussed.
- The nursing staff we spoke with were able to describe the process for escalating emergency issues, such as violence, absconders, safeguarding, Child and Adolescent Mental Health Services (CAMHS) issues, non-accidental injury (NAI) and bed management issues.
- We attended the neonatal handover and saw that safety checks were announced and that at the bedside handovers, complete information about each baby was communicated to the nursing staff.
- Children's services used the London neonatal transfer service or the Children's Acute Transport Service (CATS) to initiate a retrieval for babies or children requiring a period of intensive care. Sick babies and children could be cared for within children's services until such time as the transfer was expedited.
- Resuscitation and basic life support training formed part of the trust's mandatory training provision. Of medical and dental staff within children's services, only 56% had completed Basic Life support training versus the trust target of 90%. Nursing staff met the 90% target and additional clinical services staff were just below the target at 86%. However there was always at least one member of staff on duty qualified in advanced paediatric life support.

Nursing staffing

- The service risk register dated June 2016 identified risks related to nurse staffing within both the paediatrics and neonatal services. This was attributed to a 20% vacancy factor and by three whole time equivalent (WTE) maternity leave vacancies. Nursing staff deficits had

triggered the senior management team to submit a business case in order to increase funding to recruit additional nursing staff and to reduce the over-reliance on agency staff.

- Although the service had plans to recruit to 95% of capacity by September 2017 ongoing recruitment strategies had already positively impacted on reducing the overall burden of low nurse staffing from 40% to the current 20% figure. A senior nurse manager we spoke with told us that there was a particular problem in recruiting band 5 nursing staff. She was planning to develop a recruitment video about the benefits of working within children's services at Whipps Cross and promote this by using social media to boost recruitment among this grade of staff.
- We noted that the paediatric service had been without a permanent band 7 matron for over a year. We were informed however that this situation was being addressed and that a matron had been recruited from Great Ormond Street Hospital and who was scheduled to commence duties in September 2016. However junior staff had access to a senior children's nurse for advice at all times throughout the 24 hours period and there was always a nurse on duty with an advanced paediatric life support qualification.
- Adherence to the 2013 Royal College of Nursing guidance on staffing was only being achieved through the use of bank and agency staff.
- At the handovers we attended we saw that there were sufficient numbers of staff available to respond to the acuity needs of the children and babies.
- Members of the medical and nursing staff we spoke with told us that there was an over reliance on the use of agency children's nurses.
- Although the risks associated with staffing were being controlled and the RCN 2013 standards pertaining to the nurse staffing of children's units and the British Association of Perinatal Medicine (BAPM) standards for staffing neonatal units were being achieved on most occasions, this was achieved through either bank or agency staff use.
- An agency nurse we spoke with told us that nurse to patient ratios in some areas were pressurised and on some occasions there was only one nurse on duty in the

Services for children and young people

day surgical unit and that on at least five occasions in the recent past that nurses had been moved from day surgery to the general ward because of staff shortages. We were told that sometimes the nurse would have to collect children from theatre leaving only a HCA to care for post-operative patients.

- Despite the introduction of electronic (e) rostering, nurses told us that most of the time that they were short staffed. However, nurses also told us that they personally felt safe and supported by the senior staff and that there had been no episodes of bullying.
- During our inspection of the neonatal unit we noted that the ward dashboards/thermometers were up to date but that the staffing ratio recorded for the day was incorrect.
- One of the consultant paediatricians told us that nurse staffing had improved over the last year although some others told us that they still had concerns about nurse staffing.
- We spoke with an agency nurse on the neonatal unit who told us that she kept coming back to work there because it was such a nice unit.
- Senior nurses we spoke with told us that they were very reliant on agency and bank staff to meet the RCN standards but that there was always a band 6 nurse on duty.
- A parent told us that he had concerns with the number of nurses on duty at night, although other parents told us that there was always plenty of staff on duty.
- Junior doctors told us that although they thought that there were enough doctors they had concerns with the amount of agency nurses that were being used. However they all felt that staffing had improved over the last year.
- There were systems in place such as e rostering and the use of daily huddles for ensuring that the clinical needs of patients were assessed and staffing levels adjusted accordingly.
- We observed nurse handovers in both neonatal and paediatric areas and noted that the staff demonstrated a good understanding of patient need, including social needs and relationships with family.

Medical staffing

- Consultants told us that children's services were short of consultant cover and that the volume of work was too high.
- We were also informed that changes to registrar training allocation by the London Deanery meant that as from September 2016 that there would be a shortfall within children's services of 2.5 registrars.
- Senior managers of children's services told us that that Whipps Cross was failing to achieve safe staffing levels as recommended by the Royal College of Paediatrics and Child Health (RCPCH). The RCPCH recommends for a children's service like Whipps Cross there should be 18 WTE consultants whilst only nine were currently employed. Despite this all standards relating to the care of sick children including access to a paediatric consultant at all times were being met.
- The neonatal consultants told us that they were failing to fully meet BAPM standards on the neonatal unit. We were told that there was always a consultant service available for the neonatal unit and that they followed the BAPM guidelines for medical staffing of Special Care Units (SCU) which provided special care for the local population. However, the unit at Whipps Cross also provide by agreement with their neonatal network, some high dependency services. Additionally a registrar was available 9am-5pm Monday to Friday with additional help from a junior doctor. However, staffing was compromised because of the on-going shortage of middle grade doctors caused by the Deanery changes to commissions.
- Medical consultant cover and medical registrar cover was available 9am-5pm within children's services Monday to Friday.
- Three junior doctors were available within the neonatal unit during the day and after 5 pm we were told that a consultant was available to cover both the neonatal unit and the children's ward assisted by two registrars, additionally two or three junior doctors were available after 8pm within paediatrics and one for the neonatal unit. Hence there was three layers of medical staffing, 9am-5pm, 5pm-8pm and post 8pm.
- Weekends were covered 9am-3pm by a consultant and after 3pm one consultant covered both paediatrics and neonates.
- Children's services aspired to have 16 consultants to accommodate a split rota within paediatrics and

Services for children and young people

neonates. Tangible plans had been developed to increase consultant employment to 11 and we were told that recruitment for these additional post had been initiated. The current consultants believed that the existing workload and levels of child acuity justified a consultant workforce of 16 WTE.

- Our inspection of the medical roster demonstrated a shortfall in medical cover. The most difficult area of the roster to fill was the senior registrar section because of the shortfall of 2.4 posts attributed to the cuts to Deanery commissions. Consultants told us that the Deanery was not very responsive to issues such as maternity leave. To alleviate the shortfalls, locums were being used on most days. To mitigate risk, the locums employed had previous experience and were well known to the consultants. Hence 90% of the locums used were regularly employed within children's services. Children's services also relied on using its existing cohort of doctors to fill roster vacancies through the hospital medical bank. We were told that agency medical staff were only used when the in house bank arrangements were unable to provide cover.
- Where concerns had been raised about the skills, competencies or behaviour of agency medical staff by members of permanent staff steps were put in place to suspend their future employment. To further mitigate risk CVs were screened and inspected by consultants prior to shifts commencing. We were told that Inductions of agency doctors were consultant led and that many of the agency doctors had Whipps Cross cards which could take up to six months to obtain.
- We were told that in some cases although not ideal, experienced junior doctors acted up as registrars.
- Medical cover at weekends and other periods did not always meet the demands of the service or the needs of patients and when we examined the roster spreadsheet to ascertain the use of locums we noted that where shifts were not filled that this was red flagged on the spreadsheet and this was the action which triggered agency use. We were told that there were real difficulties within the medical workforce in meeting the EU working time directive and we were shown the email trail of concerns about staffing to the medical director who we were told was fully aware of the issues related to

medical staffing. The European Working Time Directive (EWTD) is an EU initiative designed to prevent employers requiring their workforce to work excessively long hours, with implications for health and safety

Major incident awareness and training

- The senior nursing and medical staff told us that they had received major incident awareness training. Staff told us that they were aware of the major incident plan and knew how to access the plan via the trust intranet. We inspected the major incident plan and saw that it was in date and comprehensive. Winter management plans were in place and with regard to emergency planning training, 100% of admin, clerical and additional clinical services had completed this along with 97% of nursing staff and 88% of medical staff.
- All of the staff we spoke with had recent fire safety training although data provided by the trust showed that only 73% of medical staff and 86% of additional clinical services staff had completed the training although 100% of admin and clerical staff as well as 90% of nursing staff had done so.

Are services for children and young people effective?

Good



We rated effective as good because:

- Accurate and up-to-date information about effectiveness was shared internally and externally and was understood by staff.
- Information from local and national audit programmes was used to improve care and treatment and people's outcomes.
- Performance against a range of national audits was seen to be in line with, or better than, national averages.
- When young people were due to move between services through transition their needs were assessed early, with the involvement of all necessary staff, teams and services.
- Staff adopted a holistic approach to assessing, planning and delivering care and multidisciplinary working was seen to be effective across all disciplines.

Services for children and young people

- As a result of good MDT working clinical teams worked collaboratively to enhance the provision of care to children. The service participated in a range of local and national audits, including clinical audits and other monitoring activities, such as reviews of services, benchmarking, peer review and service accreditation.
- The service had developed a sophisticated strategy for managing sick young people in hospital based on the “you’re welcome” criteria and regularly participated in “15 step challenge audits”. 15 step challenge audits were regularly used to highlight areas of good and less good practice.

However:

- Some audits such as that for the Assessment of Malnutrition in Paediatrics (STAMP) showed that there were some ongoing issues with the recording of the weight and height of children on admission. Staffing for the children’s dietetic service was below required standards.
- There was a lack of nursing procedures and guidelines with many only available as paper copies and therefore not kept updated.
- Play specialists support was inadequate and play staff were only available to work with children during school term time. This service failed to meet nationally accepted standards for the use of play in hospital.
- The phlebotomy service for children was not child friendly and was not supported by play specialists to help children with debilitating fears such as needle phobia.

Evidence-based care and treatment

- The trust’s hospital protocols were positioned around evidence based practice national guidelines and were responsive to current policies from NICE, the RCN and the RCPCH. Many of the policies and procedures such as those for the management of diabetes were available to staff through the trust intranet.
- The nursing staff could access a small range of policies and local guidelines, which were available via the intranet and we inspected a range of these policies for example the transition and outpatient DNA policy. We saw that there were systems in place for ensuring that these policies were reviewed following changes to national guidance.

- Although the nurses told us that they found the policies and procedures helpful in carrying out their day to day nursing activities, many of them were available only as paper copies and many were out of date and covered but a narrow spectrum of practice areas. We were told that plans were being considered to amend and update the nursing policies and procedures.
- Clinical governance information and changes to policies and procedures and guidance was conveyed and cascaded to nurses through the assistant director of nursing for children’s services via emails and discussion at team meetings, which were held monthly.
- We saw that there was a comprehensive paper file of neonatal doctor guidelines which covered a variety of topic areas such as “what times handovers are at, what jobs doctors need to do, what to do if a baby deteriorates, how to prevent hypothermia”. However we saw no nursing policies for the neonatal unit available via the intranet.
- Doctors told us that they could access a range of policies via the intranet or from their mobile phones.

Pain relief

- We observed that a variety of tools were used to assess pain, depending on the age of the child and their ability to understand information. The staff carried specially designed pain assessment card packs to help them access and manage children’s pain. We saw that in younger children staff used the ‘smiley faces’ Wong Baker scale which is a pain assessment tool used for children aged three or over. For older children staff utilized a 10 cm visual analogue scale where 10 is the highest amount of pain being experienced by the child. For non-verbal children such as those with learning disabilities who were not able to communicate their pain to carers we saw that the Face, Legs, Activity, Cry, Consolability (FLACC) behavioural tool was used.
- Records we inspected on the neonatal unit contained pain assessment tools.
- There was no paediatric pain nurse specialist on site although staff could request a consultation with the pain nurse specialist at the London Hospital site. A paediatric consultant anaesthetist was on site at Whipps Cross Hospital and was able to advise on pain management in children.

Services for children and young people

Nutrition and hydration

- Not all the patient records we inspected included an assessment of each patient's nutritional requirements. Children's services used the adapted Screening Tool for the Assessment of Malnutrition in Paediatrics (STAMP) to assess nutritional risk for sick children. This is a validated nutrition screening tool for use in hospitalised children aged 2-16 years. However the paediatric dietitian we spoke with told us that she had recently undertaken a STAMP compliance audit and when we inspected the data we saw that the results of the audit had been sub optimum and had shown that there were some unresolved problems with the recording of weight and height of children being admitted to hospital with two out of 11 not being undertaken. Since this audit emails reminding staff about the importance of using STAMP to assess children's nutritional status on admission had been sent. However the the nutrition action meetings did not feed into the the children's services paediatric user group (PUG).
- Sick children with either poor or restricted nutrition or hydration intake were closely monitored by nursing staff and we saw that input and output was recorded. The nursing care plans we inspected included a section for nurses to monitor nutrition and hydration.
- Parents and children told us that there were choices in the menu offered each day and that the food provided was generally good. The menu card was given to patients to select their menu and we observed that there were many choices for the children. When we examined the lunch trolley we observed that it carried a variety of healthy menu choices.
- Staffing for the children's dietetic service was suboptimum and the paediatric dietitian we spoke with told us that her work in the community accounted for up to 80% of her time and that she needed the services of a 0.5 WTE paediatric dietitian to cover fully children's services in the hospital.
- We saw that there was significant emphasis on the promotion of breast feeding within the neonatal unit due to its UNICEF accreditation status. Mothers on the neonatal unit told us that they were helped with breast feeding activities and that the nurses ensured that they themselves were eating and drinking sufficiently to carry on breast feeding.

- Patient records we examined on the neonatal unit contained accurate breastfeeding plans and fully completed expressed breast milk administration (EBM) charts.
- We saw that there were policies in place to support staff to ensure that children we appropriately fasted preoperatively, in line with national recommendations. Parents we spoke within the day surgical unit told us that they had been given precise information about preoperative fasting and that this was checked by the nursing staff on arrival on the ward.

Audit and Patient outcomes

- Children's services had participated in a range of national audit programmes in order that benchmarking and measuring of clinical effectiveness could take place. Audits participated in included the Childhood Epilepsy Audit, the British Thoracic Society Paediatric Asthma Audit, the National Paediatric Diabetes Audit (NPDA).
- The glycosylated haemoglobin (HbA1c) measurement is recognised as being the best indicator for long-term diabetes control and data from Whipps Cross Hospital shows that children with diabetes who are cared for within children's services have better controlled diabetes management than that experienced elsewhere in England.
- The paediatric diabetes nurse specialist we spoke with told us that there were six diabetes nurse specialists across the trust. We also were told that the anomalies within the multiple rate of admission for children with diabetes which at 31.8% was worse than the England average of 13.2% was actually attributable to the practice of double counting where for example, if a child is admitted with a fracture they are still annotated within the medical notes as a diabetic.
- Performance against the national clinical audit for paediatric asthma was better than the England average with multiple admission rates for children at Whipps Cross being 14.4% compared to the England average of 16.2%. This audit involves the collection of data on every child over One year of age admitted to hospital with wheezing or asthma during the month of November. The data collected is grouped into five areas:

Services for children and young people

basic demographic information such as age and sex; initial hospital assessment; initial hospital treatment; discharge treatment and asthma attack management planning; and plans for follow-up.

- We saw that the neonatal unit was meeting the requirements of the national Badger net audit and when we inspected the database we noted that it was fully updated. This software national application has been designed to provide a repository for the collection, storage, and reporting of live perinatal patient data.
- We saw that the children's services participated in the Epilepsy 12 audit data collection. This National Epilepsy 12 Audit was developed by the Royal College of Paediatrics and Child Health to determine how effectively national recommendations for the management of epilepsies in children and young people were being followed by providers such as children's services at Whipps Cross. The aim of this national audit was to assist epilepsy services, and those who commission health services, to measure and improve the quality of care for children and young people with seizures and epilepsies. We inspected the data for multiple readmissions of children and young people with epilepsy at Whipps Cross and saw that it was comparable to the national average of 29.2%.
- Staff told us that the trust improvement library held details of all the appropriate audits being undertaken within children's services.
- A paediatric pharmacist told us that controlled drugs audits were undertaken every three months with ongoing medicines management audits. A planned allergy audit was about to commence. We also saw evidence of audits being conducted for take home drugs (TTA), antibiotic use, aminoglycoside levels, and pharmacy interventions.
- One of the consultant paediatricians told us that the trust had a trust-wide initiative to fully embrace the standards embodied within the "you're welcome" audit tool. The Department of Health You're Welcome quality criteria were first published in 2005, following concerns regarding contemporary healthcare for adolescents, and a recognition that patterns of health-related behaviour laid down in adolescence impact on long-term health behaviours. An updated version was published in 2011 and established principles that enable healthcare professionals working in children's services and elsewhere to improve services by making them younger person friendly. The consultant we spoke with continued to chair the trust-wide adolescent steering group which met monthly or bi monthly and was augmented with individual bi monthly site meetings. The steering group had five young people service users colloquially known as YES (youth empowered squad). The trust admitted 8,500 11-18 year olds per year and the role of the steering group was to evaluate the best model of care delivery for young people. A variation of the model developed by Great Ormond Street hospital was being utilised and the trust had secured a year's funding for a clinical nurse specialist in adolescent care who was scheduled to be appointed in the near future. The trust was planning to undertake a full "you're welcome" audit and a specific young person's "15 step challenge". A representative from the local clinical commissioning group was a steering group member. The group also had a sexual health perspective and the clinical director of children's services, herself a consultant in sexual health, was a member of that steering group.
- The whole initiative was linked to transition from child to adult services and a commendable moving image production entitled "Bart's Transition from child to adult". had been developed and is available online. Orientated towards young people this production highlights the value of the transition passport which had been initiated and was based on the University Hospital Southampton's initiative "Transition to adult care: Ready Steady Go" which has been endorsed by the RCPCH.
- The transition passport was in line with the You're Welcome criteria (2011) and took into account the young person's maturity, cognitive ability and specific needs with respect to their long term condition in addition to their social/personal circumstances and psychological status. The families of young people had been included in the initiative and in the decision making about appropriate care for the young person. This was because it was deemed essential in facilitating a streamlined progression from paediatric to adult services.
- Additionally a trust-wide initiative to develop young person friendly clinical areas throughout children's

Services for children and young people

services had been implemented. The initiative was entitled “The Zone” and had involved young people in designing adolescent recreational centres within each clinical service across the whole of Bart’s health. The Zone within Whipps Cross is located within Acorn ward and its refurbishment had been funded by a well-known local retailer. The Zone had been part of a pan trust “listening into action” initiative which is an approach that is designed to impact on the quality of patient care by actively listening to staff and supporting them to make the changes they want to see for their patients and for the way in which they want to work.

- Staff confirmed that a “15 step challenge” was undertaken on a regular basis. The 15 Steps Challenge is a tool to help staff, patients and others to work together to identify improvements that will enhance the patient experience and was part of The NHS Institute for Innovation and Improvement’s productive ward series. The 15 Steps Challenge was a series of toolkits which remain part of the resources available for the productive care work stream. They were co-produced with patients, service users, carers, relatives, volunteers, staff, governors and senior leaders, to help audit care in a variety of settings through the eyes of patients, to help capture what good quality care looks, sounds and feels like. The 15 step challenge is so named after a parent said “I can tell what kind of care my daughter is going to get within 15 steps of walking on to a ward”.
- We were told that a variety of research projects had been undertaken within the trust as a whole for the benefit of children’s services. For example we were informed that Whipps Cross were participating in cancer research for children namely UKAL 2011 which is a national clinical trial for children with acute lymphoblastic leukaemia.
- We were also informed that children’s services were participating in sickle cell disease transition research with St Mary’s University.
- We saw that the trust initiative “listening into action” was promoting evidence based practice. This new way of working, called Listening into Action, is an approach that has been tried and tested elsewhere in the NHS. Trusts such as Bart’s Health that had adopted “listening into action” believed that it was having a positive impact on the quality of patient care. We saw numerous

posters within the hospital advertising significant clinical strategies which had been the subject of “listening into action” including the introduction of sepsis six.

Competent staff

- Staff reported that they had attended induction on starting employment and had attended mandatory training, including basic life support. Agency nurses and agency health care assistants we spoke with told us that they had attended induction prior to commencing duties within children’s services. Consultants also told us that they personally participated in the induction of agency doctors.
- Allied health care professionals were enabled to attend multidisciplinary team meetings and additionally provided teaching sessions to nurses, which helped to build team resilience.
- Staff were enabled to progress their careers through the attendance of educational courses in local universities which were discussed at their annual appraisal.
- The practice educators told us that newly qualified nurses were entitled to a period of supernumerary status as part of their preceptorship year. There were systems in place for monitoring training for new staff, through the training department. The practice educators ensured that newly qualified nurses and those going through their induction period received the appropriate training that had been arranged for them. This included mandatory training, mentorship training and competency assessments, such as for the administration of oral and intravenous medication.
- Nurse revalidation was firmly established and the outpatient senior nurse we spoke with told us that she was due for revalidation with the NMC in 2017. She reported that the trust had been very supportive in providing revalidation workshops for staff to attend and that through Wired she was up to date with her mandatory training requirements.
- The medical consultants we spoke with told us that arrangements for medical revalidation were fully embedded within children’s services.
- Nursing staff on the neonatal unit were enabled to attend programmes of study leading to the recognition of ‘qualified in specialty’ status (QIS). These post

Services for children and young people

registration education pathways, in collaboration with service providers, allow for registered nurses working in neonatal units to become equipped with the specific knowledge and skills to practice safely and effectively in this critical care area. We saw that all nursing staff working on the neonatal unit had completed their new-born life support training.

- Staff working within paediatrics had all completed the paediatric intermediate life support course (PILS).
- Junior doctors we spoke with all told us that they received high quality educational support from their consultants and at the medical handovers we attended we saw that consultants used the occasions for impromptu teaching of junior colleagues. Furthermore at the MDT neonatal meeting we attended we saw that the consultant used the occasion to provide teaching for the team on specific aspects of individual children's morbidity.

Multidisciplinary working

- Overall, staff reported good multidisciplinary working across the children's services and with other services within the trust and with external organisations such as CAMHS and the local authority which provided and staffed the hospital school with teachers and play specialists. There were good shared care arrangements with other London tertiary trusts for children with cancer. The North and South Thames commissioners have established shared care arrangements for children within District General Hospitals across the region, which allows patients to receive agreed treatments closer to home.
- Children in transition were enabled to join the trust wide initiative "Bart's Transition from child to adult".
- Apart from the term time, play specialist who were part of the hospital school there were no qualified play specialists available in the areas that sick children were seen and treated e.g. outpatient clinics, A+E, phlebotomy, radiology etc.
- One physiotherapist we spoke with told us that MDT working within the children's services team was very good. "I think MDT working is great" and she told us that she had good working relationships with the consultants.

- We attended the MDT meetings within the neonatal unit and saw that the psychosocial aspects of care of babies close to discharge were considered first.
- Daily MDT huddles and weekly MDT meetings were held and included as appropriate discussions on serious case reviews, general safeguarding concerns and psychosocial aspects of care. At the meetings we attended we saw that in this way the care and treatment of each child and family was discussed and different views were listened to before making decisions in the best interests of the child concerned.
- The paediatric pharmacist we spoke with was highly complementary about MDT working "I think it is amazing –they are all very approachable".
- The consultant paediatrician leading on transition told us that the paediatricians had excellent links with their adult consultant colleagues and that MDT working across the children's services was good.
- CAMHS support for children with emotional or mental health problems was available on-call.
- The staff of the outpatient department told us that MDT working was very effective and a band 7 nurse told us that all levels of staff worked well together and that she personally knew the names of the porters and ancillary staff who worked in children's services.
- All staff we spoke with told us that there was no culture of bullying and that they all felt comfortable in raising and escalating any concerns they might have about care delivery.
- The student nurses we spoke with told us that they believed that all staff were very approachable and that MDT working was good. One of the students told us that she had been offered a post within children's services on a rotational contract

Seven-day services

- Play specialists were only available to work with children during school term time and they worked for the hospital school through the local authority. There was no specific play specialist provision during the period of the inspection which was conducted during the summer school holidays. Out of term time and at other periods including weekends sick children with specific play requirements or those needing specific

Services for children and young people

diversional interventions as in the case of children with debilitating fears such as those with needle phobia were not able to access such support. Children's services at Whipps Cross failed to meet the play requirements of children as stipulated by the National Service Framework.

- The current medical establishment was insufficient to provide overnight on site consultant paediatrician presence. Out of hours care was provided by registrar cover with access to an on call consultant. We were informed by senior nurses we spoke with that the hospital at night team consisted of an on call consultant supported by a ward based registrar and junior doctor. There was always a safeguarding lead, pharmacist, and physiotherapist on call. Additionally a night site manager was available for advice. Liaison with the neonatal unit and the children's emergency department was utilised for help and advice.
- The paediatric physiotherapist we spoke with told us that her service was a five-day service with on call availability for Acorn ward and with occasional Saturday and Sunday on call cover.
- The senior nurse in the outpatient department told us that the clinics were mainly held Monday to Friday and that there were up to 10 clinics per day. Although the outpatient department does not have play specialist input the HCA who worked there was a qualified nursery nurse. She also has phlebotomy expertise and was sometimes available to work with children with needle phobia.

Access to information

- Staff told us they were frustrated with the trust's IT facilities which sometimes slowed down their ability to find relevant information.
- All the information needed to deliver effective care and treatment was available to relevant staff in a timely and accessible way through care and risk assessments, care plans, case notes and test results.
- When people move between teams and services, including at referral, discharge, transfer and transition, all the information needed for their ongoing care was shared appropriately, in a timely way and in line with relevant protocols.

Consent

- The parents we spoke with in children's services including the outpatient department told us that their consent had been sought prior to treatment of their child and that the nurses or doctors had asked for the child's agreement before performing any procedure. For example during our visit to the operating department we saw that children undergoing anaesthesia were asked by the anaesthetist for their consent before administering the anaesthetic which helped put the child at ease.
- Parents described how the procedures had been explained to them by both doctors and nurses. They felt they had been given very clear information and were well informed before they signed the consent form for surgery and or treatment.
- All the medical and nursing staff we spoke with including students were able to describe to us the legal aspects of consent. They were all aware of the policies and procedures that were available to them to ensure that informed consent was obtained from children and their parents or carers. Similarly staff fully understood the notion of Gillick competence and the arrangements for seeking consent from children and young people where they had been assessed as being competent to make decisions regarding their care and treatment.
- Staff were aware of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards and were able to describe the arrangements that were in place should the legislation need to be applied.

Are services for children and young people caring?

Good



We rated caring as good because:

- Parents we spoke with were pleased with the care their children had received from the medical, allied health care professionals and nursing staff.
- Parents told us that they felt that their children were in a safe place and that their needs would be met at all times by staff.
- Parents told us that they were fully involved in the care delivery of their children and that health care professionals kept them informed at all times as to the

Services for children and young people

progress of their individual children. We saw that there was good staff interaction at all times with the children and their families. Parents told us that they and their children were treated none judgementally with compassion, dignity and respect.

- We observed that all staff treated patients and relatives with dignity, respect and compassion.
- The service had introduced a “tops and pants” innovative system for gathering feedback from children and family members.
- Data from the children’s survey in 2014 showed that children’s services at Whipps Cross scored higher than the national average in two domains.

However:

- Care provided on the neonatal unit was constrained by the poor and outdated physical environment of the unit.

Compassionate care

- Throughout our inspection, we witnessed good staff interaction with patients and parents. We observed good, friendly and appropriate communication by nursing and medical staff with parents and their child. Nurses we spoke with told us that children and their families were always treated with the utmost respect.
- We observed how the nurses prepared children and their families for surgery putting them at ease and when we accompanied one child and his parent to the operating theatres we saw that the anaesthetist involved them fully during the period in the anaesthetic room which had been decorated to make it child friendly. We observed the theatre staff fully involving the child in conversations which were age appropriate.
- Medical and nursing staff told us that they would be happy to have their own children admitted to children’s services at Whipps Cross and all the staff were aware of the 6C’s and believed that it was embedded into their own ethical practice. The 6C’s are a set of values that underpin compassion in practice, a vision and strategy for nursing, midwifery and care staff.
- Parents told us that they were very happy with the nursing care that their children received and that the “doctors work from their hearts”.

- At one of the MDT meetings within the neonatal unit we attended we saw that the bonding aspects of care and the visiting practices of parents were fully discussed. We noticed that situation of teen mothers were debated with reference to future safeguarding issues.
- At one of the early morning nursing handovers we attended on Acorn ward we heard many examples of caring being demonstrated when discussing the progress of individual children. One child was celebrating their birthday in hospital and one of the nurses had baked them a cake to enhance their day in hospital.
- Although the period of our inspection was during the summer school recess and there were no play specialists available, parents we spoke with told us that they thought the play room and the outside play garden were well equipped and enhanced the stay of their children.
- Parents and children in the outpatient department told us that staff always spoke to them using language that they could understand and that the nurses always addressed them and their children by their names. Parents told us that the department was child friendly.
- We saw that the service had introduced a “tops and pants” innovative system for gathering qualitative data from children and family members about what they liked best and what they liked least about the service. “Tops and pants” is used by some children’s units around the country as a way of ensuring that the views of children and their families and the “children’s voices” are heard, listened to and acted upon. In this way the children had been invited to write down on “post its” in the shape of a T shirt and a pair of shorts what had been ‘tops’ or ‘pants’ about their stay in children’s services. We saw that the children had fully embraced the idea and that the staff had displayed their “tops and pants” on a special notice board on the ward and had given information on how they had responded to any “pants” comments or observations.

Understanding and involvement of patients and those close to them

- During our observations we saw numerous examples of allied health care professionals involving children and their families in their care. For example in the physiotherapy department we saw that the therapist demonstrated caring and compassionate attitudes.

Services for children and young people

- The parents told us that they had been well informed particularly prior to their child's surgery. Parents felt comfortable about signing consent forms on the basis that they had received all the information to make an informed choice. Parents were unanimous in feeling fully involved in the decisions pertinent to their child's care and management during the hospital stay.
- Data from the children's survey in 2014 showed that children's services at Whipps Cross scored higher than the national average in two domains. Firstly staff were complimented on their ability to fully explain planned procedures to family members and secondly that staff were good at explaining how procedures had gone to children aged 8-15 years.
- Parents reported they were given appropriate information on all aspects of care by each member of the multi-disciplinary team they had contact with. Information was given in a child friendly format and we saw doctors and nurses engaging children in dialogue which was couched in language they could understand.
- We saw that theatre staff took great care in explaining to both parents and children what was about to happen.
- Referral to treatment times for patients waiting to use services within the children and young people's directorate were generally good. The service was consistently meeting the national target that at least 92% of patients should spend less than 18 weeks waiting for treatment.
- Within the area of adolescent transitional care there was a trust-wide service user engagement strategy.
- A specially designed Friends and Family Test questionnaire facilitated the collection of data from children and their families about their hospital stay.
- Outpatient efforts to ensure greater clinic appointment compliance was facilitated through the use of text messages.
- Staff within the outpatient department had robust procedures for managing situations where children and their families failed to attend clinic appointments.
- Children's discharge or transition plans reflected their individual needs, circumstances, ongoing care arrangements and expected outcomes.

However:

- Staff acknowledged that patient involvement was still at an early stage of development and no attempt had been made to engage with the wider child community of the Whipps Cross geographical area.
- Facilities for parents, carers and visitors including accessible toilets and showers, drinks rooms and snack facilities were basic. Acorn ward had no on site parent accommodation rooms available.
- Children with learning disabilities were not flagged and there was no clinical nurse specialist with responsibility for such children in the hospital. Health care staff were not equipped with the specific skills such as Makaton to communicate with this group of patients.

Emotional support

- A range of healthcare specialists were available to provide emotional support to families and to children. Bereavement support was available and we saw that a band 7 nurse was in post to liaise with the local hospice and other members of the care team.
- We saw that there were a range of clinical nurse specialists in post and that CAMHS services were timely and responsive to the emotional needs of children with mental health conditions.
- We were told that the hospital school addressed many of the emotional needs of children through the services of the play specialists during term time.

Are services for children and young people responsive?

Good



We rated responsive as good because:

Service planning and delivery to meet the needs of local people

- Daily huddles took place, allowing the staff to discuss their bed occupancy, post-operative management, upcoming discharges, elective and emergency admissions and safety issues.
- We noted that young people were cared for within the children's and young people's service and saw evidence that their transition into adult services was managed effectively through the pan trust adolescent steering group.

Services for children and young people

- The service employed a range of clinical nurse specialists to ensure that children and young people with specific health conditions such as diabetes and their families received expert care and support.
- The children's survey of 2014 showed that Whipps Cross children's services performed better in giving choices of admission dates to parents when compared to the national average.
- Although Acorn ward had no on site parent accommodation rooms available, parents were able to sleep by their child's bedside. The neonatal unit was in need of upgrading to offer better facilities for parents.

Access and flow

- Referral to treatment times for patients waiting to use services within the children and young people's directorate were generally good. The trust provided us with data for 'incomplete pathways', which are waiting times for patients waiting to start treatment at the end of the month, for April to July 2016. The service was consistently meeting the national target that at least 92% of patients should spend less than 18 weeks waiting for treatment. Paediatric endocrinology was the only area where the target was not met, however this was only for two patients in July 2016 (80%) and in all other months we reviewed this had been 100%.
- The multidisciplinary team conducted daily board rounds to review the ongoing care needs of children including discharge planning for each patient
- Parents within the outpatient department told us that outpatient referrals were not always timely and that sometimes they had to wait several months for an appointment. One parent told us that clinics were cancelled at short notice leading to further delays of up to three months and that when she telephoned the outpatient department for further information that she was not taken seriously and that her questions were not fully answered. However, staff we spoke with in the outpatient department told us that outpatient clinics were rarely cancelled and where necessary other consultants or middle grades would provide cover for individual clinics. However, data supplied by the trust showed that the hospital cancellation rate for paediatric outpatient clinic appointments, provided by the trust for July 2016 was 32.4%, whilst patient cancellations for the same month were 8.3%.
- The outpatient 'did not attend' (DNA) rate was seen to be well managed with procedures in place to ensure that children came to no harm from conditions which might deteriorate over time and become exacerbated by a failure to attend monitoring clinics. The DNA rate reported for July 2016 was 13.9% for general paediatrics and 14.3% including speciality clinics.
- We saw that the phlebotomy service was not child friendly and during our observation of it we noted that the white board advising patients about the service was showing a sixty minute wait. We saw that children were not prioritised and had to wait as did the adults. We saw three young children waiting during our inspection and the ward clerk told us that parents often complain about the poor phlebotomy service. We also saw that the doors to the phlebotomy sampling room were open thus allowing children to potentially witness procedures taking place. The risk was partly mitigated by the orientation of the chairs which ensured that children had their backs to the doors. During our visit to the service we saw that the waiting area was so full that there were insufficient seats available for patients and that it had run out of blood sampling tickets by 10.30 am. The department clerk we spoke to told us that she sometimes felt vulnerable when dealing with the anger and frustration of parents attending phlebotomy services with their children. Although she told us that she was usually successful in deescalating these occurrences, she has been in situations when she had contemplated calling security for her own personal safety. We were in the department for thirty minutes and when we left the children were still waiting for their blood to be taken.
- Staff in the outpatient department told us that all of the paediatric clinics operated from the children's outpatient department with the exception of ophthalmology, orthopaedics and ENT which were scheduled from adult outpatient departments. The ENT department offered up to four dedicated child only clinics per week. The orthopaedics and trauma outpatient clinics were shared with adults, however, there was a separate seating area for children.
- The sister of the paediatric outpatient department had tried to make these adult outpatient departments more child friendly by supplying toys and child friendly chairs etc. Although the primary aim of the adult area paediatric clinics was to keep children and adults apart,

Services for children and young people

we observed that the waiting areas for children were not particularly child friendly and staff from the paediatric outpatient department often spend their own money on buying colouring books and crayons for children to use in these adult areas.

Meeting people's individual needs

- There was a lack of information leaflets available for many medical conditions although copies of information leaflets produced by some well-known charities were available.
- Allied health professionals such as pharmacists and dieticians had a frequent presence within the children's services clinical areas.
- Few staff had formal training in communicating with patients with learning disabilities and there was no access to a specialist learning disabilities nurse.
- Parents told us that staff always gave them information in a way that they could understand.
- People whose first language was not English were enabled to access interpreters and the staff we spoke with told us that language line was freely available and that interpreters could be booked at any time.
- Children with learning disabilities were not flagged and there was no specialist nurse available within the hospital. Although we were told that the play specialists and the school teachers had some experience of using Pecs or Makaton no other member of staff processed such competencies. Makaton is a speech and language programme that uses a multi-modal approach of speech, signing and symbols to support the communication of children and PECS (Picture Exchange System) is another communication strategy for children with learning disabilities which uses pictures to represent the voice of the child.
- Adolescents had access to a separate recreational area which had been funded by a local retail chain.
- We noted that there were some information leaflets which had been made available to families through various well-known charities but that there were no specific Whipps Cross information leaflets for the various paediatric conditions.
- The children's menus included various cultural dishes reflecting the local community and snacks were available at any time.
- Additionally, staff were able to offer children snack boxes at all times of the day containing for example sandwiches, fruit and drinks. Parents we spoke with told us that they were offered drinks on admission and that their children were offered snack boxes.
- Mothers on the neonatal unit received good support for managing breast feeding.
- The children's play room and play garden was well equipped and child facilities were provided with toys, colouring books and games to entertain children. However play specialists were only employed during term time with no cover in the evenings or weekends. Diversional play during procedures could not be provided out of hours. However children attending the paediatric eye clinic were supported by a nursery nurse who provided distraction during ophthalmic procedures.
- Children were given educational support five days a week during term time and teachers gave a choice of subjects for the children to choose, depending on their age group. All activities were documented in accordance with education guidelines. The education team were able to provide specialist support to children living with learning and complex physical disabilities. The hospital school was large and well equipped although it was closed during the period of our inspection because of the summer school recess.
- Children's services operated flexible visiting times to enable parents to visit or to stay with their child at all times but parent accommodation within Acorn ward was basic consisting of fold out beds.
- Translation services were available to those patients and families for whom English was not their first language.
- Children who required support for mental health conditions were routinely nursed on a one-to-one basis where ligature checks were performed. Links with local CAMHS was perceived to be good and timely and staff told us that when necessary specialist mental health nurses would be employed through an agency to care for these children.
- Children's services at Whipps Cross had access to a range of clinical nurse specialists, but that there were some concerns raised as these were trust-wide

Services for children and young people

employees and for example, the paediatric pain nurse specialist was based at the Royal London Hospital and would not be routinely involved in day-to-day pain management.

- Link nurses were in post in all areas of children's services most and were responsible for a range of policy implementations including safeguarding and infection control.

Learning from complaints and concerns

- Between May 2015 and April 2016 there were 10 complaints made to the trust relating to children's services at Whipps Cross Hospital. Five of these complaints related to diagnosis/treatment, two related to delay in care and another two to communication issues and one due to a medication error.
- The assistant director of nursing for children's services reviewed all formal complaints received from the Patient Advice and Liaison Service.
- All concerns raised were investigated and any learning from complaints was disseminated to the whole team to improve the family experience within the service.
- We saw that complaint levels within children's services were generally low and the staff we spoke with told us that they always endeavoured to resolve issues in the first instance by speaking with family members.
- Children's services used a specially designed friend and family test questionnaire to get feedback on care delivery. The "did your child get great care today" questionnaire for parents and the "I want great care" questionnaires for younger and older children were very helpful in allowing service users to make confidential reports whilst having their anonymity protected through the use of ballot boxes.

Are services for children and young people well-led?

Good



We rated well led as good because:

- Many staff had been provided with information on trust developments, cascaded through regular executive emailed bulletins from the trust.

- The organisational structure of the trust encouraged the sharing of governance from the board to the ward.
- Children's services demonstrated how they improved services or facilities based on family feedback, including through the trusts 'I want great care' programme which had been specially adapted for children.
- Child health care professionals reported good management support from their line managers and the appointment of a specific assistant director of nursing for children's services at Whipps Cross had been perceived by staff to have had a positive impact on the service.

However:

- The ongoing staffing capacity issues which had been identified in both clinical domains and not fully addressed had the potential to impact on overall care delivery.
- Not all staff we spoke with fully understood the corporate trust vision and values.
- The Acorn ward matron's post had not been filled for a year and staff felt that the service would only substantially improve when the post was to be filled later in 2016.
- Some senior staff members on the neonatal unit appeared unable to fully utilise the e-rostering system and were unable to reconcile baby acuity with staffing levels.

Leadership of service

- Leadership of the service was by way of a triumvirate with a clinical director, an assistant director of nursing and a general manager.
- Staff told us they received excellent care and support from their senior colleagues.
- Every three months a children's and young people's board meeting was held and chaired by the chief nurse and the chief medical director who was the official the children's champion for the trust.
- The daily safety huddles which took place were supported by all staff we spoke with.
- The practice development nurse told us that they believed that leadership had improved over the previous year and that team work to facilitate optimum

Services for children and young people

working had also improved significantly. However, they also said there was a lack of communication across all sites within the trust. One of the specialist nurses we spoke with told us that the leadership of the service within Whipps Cross was improving and told us, “I love it here”.

- The management team had recognised that there were significant shortfalls in staffing across children’s services and steps had been taken to resolve some of these issues including the appointment of a matron on a secondment contract from Great Ormond Street Hospital. Additionally the assistant director of nursing was planning to use social media as a means of improving recruitment.
- Morale across children’s services had improved since the appointment of the assistant director of nursing and the staff we spoke with were highly complementary about the frontline management team. The assistant director of nursing was highly visible across the service and staff we spoke with told us that her presence was motivational. The junior doctors we spoke with were complimentary about the consultants who were perceived to be very approachable and supportive.
- Generally the nurses we spoke with believed that morale had improved across all parts of the service and this was evident through nursing students wishing to return to work in substantive posts after completion of their training. Additionally, staff were all supportive of the way in which equality and diversity was promoted within the team, for example staff undertaking Ramadan being enabled to abide by their religious commitments.

Vision and strategy for this service

- The strategic vision for the sustainability of the clinical academic group included both short and long-term priorities and included developments regarding the environment, finance, service provision and governance arrangements. One of the specialist nurses we spoke with told us that the services within Whipps Cross were improving, and said, “I love it here”
- The junior doctors and nursing staff within children’s services told us that they received the monthly emailed newsletters from the executive team at the trust and that they were aware of the bigger trust picture.

Governance, risk management and quality measurement

- Regular child health services quality and governance meetings, chaired by the clinical director were held and attended by a range of health professionals, including nursing staff.
- The risk register clearly identified risks to the services and tangible plans to mitigate risk had been implemented.
- Children’s services demonstrated how they improved services or facilities based on family feedback, including through the trusts ‘I want great care’ programme which had been specially adapted for children. .

Culture within the service

- One of the senior nurses we spoke with told us that she had worked within children’s services for two years and had only intended to stay at Whipps Cross for a short period but she “fell in love with the place” because it had all the attributes of an older style hospital with a good atmosphere and high levels of friendliness.
- There was an open culture amongst the staff group and staff felt confident to report incidents and concerns in all clinical settings where a high reporting and low harm culture was encouraged.
- As part of the trust’s transformation project to re-engage staff and improve working morale and patient safety, each member of staff had been issued with a pocket card detailing contact details for key departments. This included a range of services provided for staff to speak in confidence when they had problems or concerns. This included a dedicated ‘Speak in Confidence’ team, an external ‘Guardian Service’, a ‘Confidence in Care’ employee assistance service and a team of ‘Dignity at Work’ advocates. This formed a package of care for staff to help them feel supported and valued at work and to avoid concerns reducing the quality of care they provided.

Public engagement

- Innovative systems had been introduced to seek feedback from children of all ages about their experience of being a patient in hospital. The paediatric ward displayed a ‘You said, we did’ board based on the

Services for children and young people

“tops and pants initiative” at the entrance. This was part of the trusts implementation of the ‘I want great care’ scheme that encouraged patients and relatives to give candid, constructive feedback about their experiences.

- 15 step challenges had been implemented as a way of illuminating more clearly the child and family health care journey.
- Significant efforts to engage with young people under the “You’re welcome” criteria had been introduced and engagement with the YES group had led to improvements in transition to adult services.

Staff engagement







- The trust had engaged staff in a survey to monitor improvements in empowerment and morale following a period of significant change in leadership and governance structures. This formed part of a ‘safe and compassionate’ improvement plan for staff of all grades and asked 15 questions about how staff felt about working at the trust.
- It was not always evident that all staff groups were listened to in relation to their concerns. For example, senior paediatricians had raised concerns about the

lack of specialty medical cover during weekends and out of hours in light of the lower rate of consultant employment within the service when compared to the medical workload. However, nothing had been done to address this.

Innovation, improvement and sustainability

- The risk register had identified that the drugs preparation room on Acorn ward was no longer fit for purpose. We saw that capital funding had been made available to provide a larger and more comprehensively equipped drug preparation room and we noted that the building work was almost complete during our inspection.
- Innovation in applying the 'You're Welcome' criteria to the design of a young person transition strategy had improved transition to adult services.
- The risk register had highlighted ongoing staffing capacity issues which had been identified in both clinical domains. Robust strategies to mitigate risk had been identified including plans to recruit nurses from the Philippines. However, reliance on temporary staffing was ongoing.

End of life care

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

Information about the service

End of life care at Whipps Cross University Hospital is provided on all general wards supported by a consultant-led palliative care team. Whipps Cross University Hospital had a specialist palliative care 11 bedded inpatient unit, the Margaret centre. This was dedicated to provide end of life care to patients with life-limiting illness. The Margaret centre ran a 24 hour advice line for patients, carers and healthcare professionals. End of life care was also delivered where required by ward staff throughout the hospital.

The hospital palliative care team (HPCT) provided support and advice to staff across the hospital for those patients who had complex care and/or symptom management. Emotional support was available for family and friends of end of life patients. The team included specialist palliative care nurses. Between January 2015 and December 2015 there were 3,022 in-hospital deaths. For all in-hospital deaths April 2014 to March 2015, there were 758 referrals to the specialist palliative care team, 55% were non-cancer patients and 45% cancer patients. Between April 2015 to March 2016 there were 762 referrals, 45% cancer and 55% non-cancer patients. Non-cancer patients had illnesses such as heart failure and other heart conditions, dementia, renal failure and respiratory disease. The team offers short term or long-term support to patients or provides advice and support to ward staff caring for patients at the end of life.

During our inspection we visited seven wards, the emergency department and critical care unit where end of life care was provided, the bereavement centre, the chapel

and the body storage area. We spoke with seven patients, ten relatives and 30 staff, including staff nurses, health care assistants, ward sisters, members of the specialist palliative care team, porters, chaplaincy, mortuary and the bereavement staff.

We observed interactions between staff and patients, and their relatives. We looked at 30 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) orders and 20 medical and nursing care records. Before our inspection, we reviewed performance information from and about the hospital.

End of life care

Summary of findings

Overall we rated end of life care as requires improvement because:

- We observed patients were visibly in pain, but staff did not respond to this by providing them with adequate analgesia.
- There were examples of lack of compassionate care. One patient looked dirty with stains all down the front of their nightwear and staff had neither noticed it nor took any actions to wash and care for the patient.
- The chaplaincy department were trying to cater for all spiritual needs but the support that is required is poorly discharged. The needs and preferences of patients and their relatives were not central to the planning and delivery of care at this hospital.
- Relatives of families of deceased were invited to a thanksgiving remembrance service held every November. If the death took place at the Royal London Hospital, the families received a formal invitation card in a bereavement pack given at the hospital. However, if the death took place at the Whipps Cross University Hospital, families did not receive such an invitation card in the bereavement pack to attend such a service.
- The hospital participated in the National Care of the Dying Audit in May 2015 and in 2016. The hospital performed worse than the England average in most areas for both audits. The service had been slow to start actions and make changes to improve end of life care for patients.
- Palliative care consultant staffing was not in line with national guidelines. Risk and learning outcomes were not clearly identified. There were three different versions of the “do not attempt cardio pulmonary resuscitation” (DNACPR) forms. Not all staff were aware of the latest version being used throughout the hospital.
- The trust had introduced the ‘compassionate care plan’ (CCP) to replace the Liverpool Care Pathway after its national withdrawal in July 2014, and to meet the requirement for individualised care plans.

Its use was not yet embedded in practice across all areas of the hospital. There were instances where dying patients were not prescribed ‘anticipatory medicines.’ These are those medicines that are prescribed for use on an ‘as required’ basis to manage common symptoms that can occur at the end of life.

- End of life care training was provided during induction but there was no mandatory on-going end of life care training for consultants. Most but not all DNACPR forms we inspected were completed according to national guidelines.
- There was limited data to suggest those patients in the last days or hours of life were in their preferred place of care. Learning from complaints was not shared at team meetings.
- The trust had developed a draft strategy for the end of life. This had not been linked with other services such as therapy services and chaplaincy.

However;

- Medicines were stored and managed safely for end of life patients. Records were complete and accessible and enabled information to be accessed to support patients’ welfare.
- There was access to syringe driver equipment and they were in line with national standards.
- Safeguarding vulnerable adults was given sufficient priority and staff were able to identify safeguarding concerns as they arose.

End of life care

Are end of life care services safe?

Requires improvement



We rated safe as requires improvement because;

- Palliative care consultant staffing was not in line with national guidelines.
- The specialist palliative care team understood their responsibilities to raise concerns and report incidents. However, details of end of life care incidents, across the hospital were not available and therefore risks and learning outcomes were not identified.
- Staff did not routinely receive feedback from the reporting of incidents.
- There were three different versions of the “Do Not Attempt Cardio Pulmonary Resuscitation” (DNACPR) forms. Not all staff were aware of the latest version being used throughout the hospital. This put patients at risk.

However,

- Medicines were stored and managed safely for end of life patients. Records were complete and accessible and enabled information to be accessed to support patients' welfare.
- There was access to syringe driver equipment and they were in line with national standards.
- Safeguarding vulnerable adults was given sufficient priority and staff were able to identify safeguarding concerns as they arose.

Incidents

- Incidents were reported through the trust's electronic reporting system. All of the specialist palliative care team we spoke with were familiar with the process for reporting incidents, near misses and accidents using the trust's electronic reporting system. As a result of incidents of pressure ulcer reported for patients last days of end of life care, patients were provided with air mattress. The incident also resulted in a change in trust policy. After this incident, air mattresses were provided to all patients whose Waterlow scores were low.
- The clinical lead for palliative care we spoke with told us that the electronic reporting system did not allow specific incidents relating to end of life care to be

identified. This deficiency in the reporting system was recognised and the trust were in the process of amending it. However, staff told us that they did not routinely receive feedback on incidents they had reported.

- The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of 'certain notifiable safety incidents' and provide reasonable support to that person. The trust monitored duty of candour through their online incident reporting system. The specialist palliative care team had a variable understanding of the duty of candour and it was not known to all staff; some staff could describe the principles of the regulation and knew of the policy.

Cleanliness, infection control and hygiene

- We observed staff adhered to the 'bare below the elbow' policy, bare below the elbow means clinical staff were not wearing long sleeves, jewellery on wrists or fingers and no false nails. Staff, washed their hands between patients and used personal protective equipment, such as disposable aprons and gloves as appropriate.
- We found the Margaret centre clean. We observed staff at the centre washed their hands between patients and used personal protective equipment, such as disposable aprons and gloves as appropriate.

Environment and Equipment

- There was enough space in the body storage area. Bodies were kept there until arrangements were made to transfer them to the main mortuary that was located off-site. Transfers took place within a window of three hours. Any transfers outside of three hours would have been recorded as serious incident. There were no such incidents since the unit had started. The facilities were clean and were well maintained.
- Syringe driver equipment met the requirements of the Medicines and Healthcare Regulatory Agency (MHRA). Patients were protected from harm when a syringe driver was used to administer a continuous infusion of medicine, because the syringe drivers used were tamperproof and had the recommended alarm features.
- There had been significant refurbishment of the Margaret Centre since the previous inspection. Patients

End of life care

and relatives commented positively of the environment. For those patients and relatives who had experienced care on the ward, they told us it was significantly better environment.

Medicines

- We reviewed the storage and administration of controlled drugs in the hospital. They were stored appropriately and medicine records were accurately completed. Emergency medicines were available for use and were checked regularly. The trust guidance on the administration and the destruction of unused controlled drugs was followed.
- There was appropriate access to syringe drivers, used to administer regular continuous analgesia (pain relief). These were available through the medical equipment library. A paper prescribing process was used for medicines given by syringe driver.

Records

- The specialist palliative care team wrote in the patient records. Decision process and discussions with relatives were clearly documented. Staff also wrote details of fast track progress and continuing care referrals.
- There was a phased implementation of compassionate care plan across the hospital.
- We reviewed the medical and nursing notes for 12 patients who were receiving end of life care. Notes were accurate, complete, legible and up to date. There was space on the form for the four hourly signature of the review of the symptoms. For example, the patient is free of pain and the box was signed. However, it was unclear what happens if a patient for example is not free of pain, and where it is documented on the care plan as to what actions have been taken. There was no evaluation of the care plan.
- We reviewed 30 "Do Not Attempt Cardio Pulmonary Resuscitation" (DNACPR) forms throughout the ward areas. All were reviewed and signed by a consultant within 72 hours. These were kept at the front of a patient's notes, allowing easy access in an emergency. However, there were three different versions of the DNACPR forms on wards. The latest version was seen in most areas. However, two other previous versions were also seen used on the wards. This put patients at risk.
- We found the latest version of the DNACPR form used at the Margaret Centre.

Safeguarding

- There was a trust policy which described the processes to safeguard vulnerable adults, children and young people.
- Safeguarding training was mandatory, all staff from the specialist palliative care and end of life care team had undertaken safeguarding adults' level 2 and safeguarding children level 2 training. Staff were knowledgeable about their roles and responsibilities regarding the safeguarding of vulnerable adults and children.

Mandatory training

- The hospital palliative care team said they had completed their mandatory training. Data provided by the hospital confirmed that all hospital palliative care team had completed all mandatory training in fire safety, basic life support, and infection control training.
- The hospital ensured end of life care training as a mandatory subject as recommended by of the National Care of the Dying Audit 2013/14 for all group of clinical staff except for consultants and specialist doctors. This anomaly was presently being looked into by the responsible officer for end of life care at Whipps Cross University Hospital. End of life care training was provided in the education programme for junior doctors.

Assessing and responding to patient risk

- The National Early Warning system (NEWS) had been established for use with all patients to identify those who are clinically deteriorating and require urgent intervention, which may prevent cardiopulmonary arrest. Nursing staff used an early warning system, based on the National Early Warning Score, to record routine observations. Where patient's physiological observations were deteriorating but full escalation of treatment was not in the patient's best interest, treatment options were discussed and a treatment escalation plan completed for the patient. The treatment escalation plan outlined the level of intervention required should the patient's condition worsen.
- The results from the National Care of the Dying Audit 2016 showed 85% of patients were recognised by the multi-disciplinary team as dying; the England average

End of life care

was 83%. Results of National Care of the Dying Audit undertaken 2016 showed 80% of patients were recognised as at end of life, just above the national average 79%.

- There have been intensive education programmes on the wards to support and improve identification and recognition of the patient who was dying. All staff we spoke with knew how to refer patients to the HPCT.
- There were daily morning handover meetings within the specialist palliative care team where they discussed all new patients. Work was prioritised and patient visits were planned at these morning meetings.
- Advice and support from the specialist palliative care team concerning deteriorating patients was available on all wards by telephone or by visit request. Staff on the wards were clear that the specialist palliative care team responded quickly to requests for advice and support.
- The hospital had withdrawn the Liverpool Care Pathway (LCP) from clinical practice in recommendations made in the publication: 'Independent Review of the Liverpool Care Pathway'. In its place the trust introduced the 'compassionate care plan' (CCP). Both nursing and medical staff on the wards told us that following the introduction of the CCP staff had been actively encouraged to refer all patients who may be approaching the end of their life to the HPCT team.
- The HPCT team had adopted the '5 priorities of care for the dying person' and had developed the CCP for the nursing and medical teams to use on the electronic patient record. The CCP focused on encouraging staff, patients and families to continue with treatment in the hope of recovery, while talking openly about people's wishes and putting plans in place should the worst happen. However, some consultant told us there was still reluctance by them to initiate such conversations due to potential legal challenge by relatives.
- We saw that patients CCP assessment and planning records were based upon the '5 priorities of care for the dying person'. Patients had individualised multidisciplinary initial needs assessments. This included space to record recognition that the patient was dying; and recorded conversations with patients and families about this.
- The CCP care plans covered the control of symptoms including nutrition and hydration, prescribed EoLC medicines, patients preferred place of care, whether there were any concerns from professionals or relatives in regards to patients care and the support patients

required in regards to their social, psychological or spiritual needs. We viewed five patients CCP and saw these had been reviewed on a daily basis by the HPCT and were up to date. However, we found there was no space in the documentation to highlight variation in care and what actions would be taken to remedy the situation. As such, the record was more of a "tick box exercise" rather than a document to improve the care given to the patient.

- We attended a safety huddle meeting on a ward. These were daily meetings where safe care was discussed and monitored on the wards. The hospital had introduced a policy that all EoLC patients would be discussed at the safety huddles. The CCP was a standard agenda item at safety huddles. Patients with 'do not attempt cardiopulmonary resuscitation' decisions (DNACPR) were discussed at the safety huddle, as well as whether or not patients were on the EoLC pathway. Staff also discussed the needs of a recently referred palliative care patient. Staff at the huddle provided feedback on whether they considered the care on the wards to be safe.

Nursing staffing

- The hospital palliative care team included three part time palliative care clinical nurse specialists (1.7 whole time equivalent (WTE) posts) who reported to the lead nurse for cancer services. They provided cover five days a week.
- There were dedicated 11 'end of life' beds at the hospital. This was provided at the Margaret Centre. Patients who required end of life care were mostly nursed on general medical and surgical wards. Nursing staff we spoke with told us they would give priority to the care of those patients in the last hours or days of life.
- The clinical lead for end of life care at Whipps Cross University Hospital informed us that there were ward champions for end of life care.

Medical staffing

- At the time of the inspection, the medical team comprised one whole time palliative care consultant, 60% of their time was providing care at the Margaret Centre and the rest of the time support on the ward. There was a 0.5 whole time equivalent post that was

End of life care

vacant. The 0.5 WTE consultant post had been appointed to on 3 May 2016 but had not yet started work at the time of the inspection. The hospital now has one consultant per 311 beds.

- As the hospital had 467 beds medical staffing was not in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations or the National Council for Palliative Care guidelines, which states that there should be a minimum of one consultant per 250 beds.

Major incident awareness and training

- Mortuary staff and the specialist palliative care team were aware of the major incident plan and actions to take in event of a major incident.
- There were 14 spaces in the body storage area.
- The chaplaincy services were on call for any major incidents.

Are end of life care services effective?

Requires improvement



We rated effective as requires improvement because:

- The hospital participated in the National Care of the Dying Audit in May 2015 and in 2016. The hospital performed worse than the England average in most areas for both audits. The service had been slow to start actions and make changes to improve end of life care for patients.
- There were instances when patients were not prescribed anticipatory medicines.
- The hospital did not provide face to face specialist palliative care services, seven days per week, to support the care of dying patients and their families or carers.

However;

- At inspection, review of records showed that patients identified as having end of life care needs were assessed, reviewed and their symptoms managed effectively most of the time.
- There was positive multidisciplinary working between specialist palliative team members, ward teams and the local hospice.
- Patient's nutrition and hydration needs were effectively managed.

- The trust had responded to best practice guidance and the withdrawal of the Liverpool Care Pathway. The service had implemented a "compassionate care plan" individual care plan.
- Ward staff reported good access to the specialist palliative care team and found they were helpful, and supportive.
- Staff had an awareness of the Mental Capacity Act 2005

Evidence-based care and treatment

- For all in-hospital deaths April 2014 to March 2015, there were 758 referrals to the specialist palliative care team, 55% were non-cancer patients and 45% cancer patients. Between April 2015 to March 2016 there were 762 referrals, 45% cancer and 55% non-cancer patients.
- The specialist palliative care team told us that following the national withdrawal of the Liverpool Care Pathway in July 2014, the trust had produced a "compassionate care plan". This met the requirements for individualised care planning.
- The service developed a draft end of life care strategy. This had yet to be formalised. This draft strategy was based on the National Institute for Health and Care Excellence (NICE) quality standard 13 (NICE QS13), which defines clinical best practice in end of life care for adults, and the Department Health National End of life care strategy.
- A new end of life care plan was introduced in March 2016, 'compassionate care plan.' This document guides delivery of the priorities of care for patients recognised to be in their last few days or hours of life, for whom no potential reversibility was possible or appropriate, and followed best practice. However, there was nowhere on the plan on the actions to take if a variance was found.
- Patient needs were assessed and care and treatment delivered in line with National Institute for Health and Care Excellence (NICE) quality standards. For example, clinical staff followed guidance relating to falls assessment and prevention, pressure ulcers, nutrition support and recognising and responding to acute illness. Staff discussed patient care of dying adults in the last days of life as per NICE guidelines 31, published December 2015.

Pain relief

- Pain was monitored using an assessment tool. Pain scoring was completed for patients every time their observations were recorded. For patients on the end of

End of life care

life care framework this was assessed every four hours. There were a few instances where patients' pain scores were high however patients were not provided with pain relief.

- The hospital used syringe drivers for end of life patients who required a continuous infusion to control their pain.
- Results from the National Care of the Dying Audit 2014 demonstrated the hospital was not in line with the England average for achieving the organisational key performance indicator 5: Clinical protocols for the prescription of medications for the five key symptoms at the end of life.
- The hospital did have procedures in place for prescribing anticipatory medicines, medicines prescribed for the key symptoms in the dying phase (i.e. pain, agitation, excessive respiratory secretions, nausea/vomiting and breathlessness). However, there were instances when patients were not prescribed these medicines. There were no audits to confirm whether patients' received medicines for symptoms and pain management.

Nutrition and hydration

- Patients were assessed using the Malnutrition Universal Screening Tool (MUST) which identified nutritional risks.
- Nutrition and hydration was included in the compassionate care plan and in all end of life care provided. Symptoms such as nausea were managed and this was documented in the patient records we reviewed.
- There was access to a specialist assessment from a speech and language therapist (for swallowing difficulties) and a dietitian.

Patient outcomes

- Patients had timely access to the hospital palliative care team (HPCT). Data provided by the hospital for June 2016, showed that 75% of patients had been seen within 24 hours of a referral being made to the HPCT. We reviewed eight medical and nursing records of patients in the last days of life and saw where the patient had been seen within 24 hours of a referral to the HPCT.
- The hospital had taken part in the National Care of the Dying Audit 2016 and only achieved one out of the seven organisational key performance indicators (KPI). The hospital was worse than the England average on all but two of the clinical indicators in the same audit. The

hospital scored higher than the England average for; KPI 1: Is there documented evidence within the first episode of care that it was recognised that the patient would probably die in the coming hours or days. Is there documented evidence within the last episode of care that health professional recognition that the patient would probably die in the coming hours or days (imminent death) had been discussed with a nominated person(s) important to the patient.

Competent staff

- End of life and palliative care training was delivered at both medical and nursing induction days. There was no input from other professions such as chaplaincy services. End of life care training was mandatory for all staff except for consultants and specialty doctors.
- Porters received training around palliative and end of life care via the hospital educator. Training included an orientation to the body storage area, health and safety training, manual handling and training on the administration duties required when registering a body in the body storage area. Porters we spoke with during our inspection confirmed they had received this training.
- The hospital participated in the National Care of the Dying Audit in May 2016. The results showed the hospital was identified as worse than the national average in relation to continuing education and training in palliative and end of life care.
- The hospital palliative team all received one to one supervision once a month and found these supervision sessions beneficial.

Multidisciplinary working

- There was a weekly hospital palliative care multidisciplinary meeting. Medical staff, nurses and social services attended this meeting. All palliative and end of life, cancer and non-cancer, patients were reviewed in relation to their care, the appropriateness of medicines and achievement of preferred place of care. Patients who were discharged or had died were also discussed, including on-going support to their families.
- All staff we spoke with were positive about multidisciplinary working. We observed interactions between specialist palliative care staff, ward based nurses and medical staff, which were professional, effective and ensured high quality care.

End of life care

- Medical consultants we spoke with said the hospital palliative care team were good at networking throughout the hospital and always responded quickly to requests for advice on patient care and treatment.
- There was little support provided by the chaplaincy service for people's spiritual and emotional needs. There was only one whole time equivalent chaplain to serve at the Whipps Cross University Hospital. There was a reliance that an additional 50+ hours of spiritual and pastoral support provided by chaplaincy volunteers every week at Whipps Cross University Hospital would enable people's spiritual and emotional needs. There was also a service level agreement with the Roman Catholic local to provide holy communion, last rites and on-call to all Roman Catholic patients RC as and when required 24/7. Additionally, Whipps Cross University Hospital chaplaincy is part of the wider Barts Health multi-faith chaplaincy team based at Newham University Hospital and Royal London Hospital as and when required. The visibility of chaplaincy on the wards still remained reactive.
- The chaplaincy services were represented on the trust end of life care committee. However, their role of supporting patients on the wards was mostly reactive, with the exception of the Margaret Centre, where they were proactive. Chaplains were mostly called on the ward to provide last rites to patients. Chaplaincy was not represented at the "Deteriorating Patient Improvement Group" that had been formed at the hospital to engage clinicians in the end of life care agenda. This absence was not recognised until we raised it with the end of life care responsible officer.

Seven-day services

- The National Care of the Dying Audit for Hospitals (NCDAH) 2013/14 recommends hospitals should provide face-to-face specialist palliative care service from at least 9am to 5pm, seven days per week, to support the care of dying patients and their families, carers or advocates.
- Specialist palliative care services, doctors and nurses, were available five days a week from 9am to 5pm.
- The consultants and specialist palliative care nurses provided out of hours telephone advice through an on-call rota. The hospital palliative care nurses told us they would contact the hospice if they needed further advice or support.

- Mortuary services were available 8.30am to 4.30pm seven days a week with on-call cover out of hours.
- Chaplaincy services were available within normal working hours and on Sunday mornings.

Access to information

- Staff had access to hospital policies and guidance specific to palliative and end of life care via the trust intranet. Staff found this resource valuable and easy to access.
- When a palliative care patient was discharged home the GP, district nurse and care agency were informed.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed staff explaining procedures, giving patients opportunities to ask questions, and seeking consent from patients before providing care or treatment. Verbal consent to treatment was recorded in all the patient records we reviewed.
- Staff were clear about their roles and responsibilities regarding the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards (DoLS). Staff had received Mental Capacity Act training and various resources were available on the trust intranet, if staff needed more support.
- We reviewed 30 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms. Twenty eight of the DNACPR forms had been fully completed to a good standard and discussions held were recorded in the nursing and medical notes. For the other two forms, the medical notes did not show, if a discussion had taken place with the patient or relatives or the patient's mental capacity assessed.
- The hospital carried out regular audits of DNACPR forms and the audit in June 2016 looked at 30 forms. The results of the audit were as follows: 20% of discussions with patients were not documented; however 75% of decisions had been signed by a consultant within 48hrs.

Are end of life care services caring?

Inadequate



We rated caring as inadequate because;

- Most patients and relatives told us their experience of care was variable. A few wards, including the Margaret

End of life care

Centre, did a good job of providing care to patients at the end of life. However, a number of wards provided insufficient care to patients and support to their relatives.

- In a few instances we observed patients were visibly in pain, but staff did not respond to this by providing them with adequate analgesia.
- There was little support provided by the chaplaincy service for people's spiritual and emotional needs. There was only one whole time equivalent chaplain to serve at the Whipps Cross University Hospital.
- There were examples of lack of compassionate care. One patient looked dirty with stains all down the front of their nightwear and staff had neither noticed it nor took any actions to wash and care for the patient.
- People's privacy, dignity and confidentiality is not respected. There was an instance of a doctor examining a patient without curtains around them.
- Relatives of families of deceased were invited to a thanksgiving remembrance service held every November. If the death took place at the Royal London Hospital, the families received a formal invitation card in a bereavement pack given at the hospital. However, if the death took place at the Whipps Cross University Hospital, families did not receive such an invitation card in the bereavement pack to attend such a service.

However;

- Some patients and relative were positive about the way staff treated people. These patients and relatives found the care met their expectations

Compassionate Care

- There were a number of instances that demonstrated that while staff understood compassionate care for end of life care patients; there were some instances that we observed that not all staff understood what compassionate care meant.
- Most patients and relatives told us their experience of care was variable. A few wards, including the Margaret Centre, did a good job of providing care to patients at the end of life. However, a number of wards provided insufficient care to patients and support to their relatives.

- There was little support provided by the chaplaincy service for people's spiritual and emotional needs on the wards. For example, there was a common understanding amongst patients and relatives on the wards that if they saw a chaplain on that ward, they would conclude that the patient was almost about to die and the chaplain had come in to give them their final rites. During our unannounced inspection, a patient whose relatives had arranged for a visit by a chaplain because they thought that the patient would find it helpful, it was the patient who commented whether the chaplain was here as they were about to die.
- There was little support provided by the chaplaincy service for people's spiritual and emotional needs. There was only one whole time equivalent chaplain to serve at the Whipps Cross University Hospital. There was a reliance that an additional 50+ hours of spiritual and pastoral support provided by chaplaincy volunteers every week at Whipps Cross University Hospital would enable people's spiritual and emotional needs. There was also a service level agreement with the Roman Catholic local to provide holy communion, last rites and on-call to all Roman Catholic patients as and when required 24/7. Additionally, Whipps Cross University Hospital chaplaincy is part of the wider Barts Health multi-faith chaplaincy team based at Newham University Hospital and Royal London Hospital as and when required.
- The visibility of chaplaincy on the wards still remained reactive with the exception of Margaret Centre where we found the chaplain providing greatest support.
- In a few instances, during our unannounced visit, we observed patients were visibly in pain, but staff did not respond to this by providing them with analgesia. When the pain recording charts were reviewed, the records showed accurate recording of data but no subsequent action. In another instance, we observed a patient in significant pain. When asked the question whether he had any pain killers, he told us that none had been given to him. When we checked his records, there was a prescription for some very strong pain killers. We found that none was given to him. This patient had been in the hospital for over ten days and his condition must have been seen by at the very least 15 people a day. Yet there was no record of the patient being offered this medicine.

End of life care

We highlighted this concern to the ward to take appropriate action. In another example, we found a patient had been prescribed two medicines for their pain: co-codamol and oramorph, a morphine derivative medicine. During our unannounced inspection, we observed a nurse asking this patient on a scale of 1 (very little pain) to 10 (unbearable pain), what rating would he give to the pain. The patient rated his pain 7. The nurse told the patient that they had been prescribed co-codamol so that would be given to him. When CQC inspectors asked the nurse as to why, when oramorph had already been prescribed to the patient, that medicine was not offered to them, we were told that the patient had not asked for it. We concluded it would have been inconceivable for the patient to ask for the stronger pain killer when he was not aware that it had been prescribed to him.

- During our unannounced inspection, we found a numbers of examples of lack of compassionate care. For example, one patient looked dirty with stains all down the front of their nightwear and staff had neither noticed it nor took any actions to wash and care for the patient. There was an instance of a doctor examining a patient without curtains around them. There was an instance when the inspectors were holding a conversation with a patient about their care, behind closed curtains, clearly indicating that the patient was busy, when without notice or asking for permission, a nurse came in loudly asking the patient in a voice that could be heard across room whether they had a bowel movement. Another patient was vegetarian and struggled to get a suitable diet. When he raised it with the nurse, he was told: "You will not get vegetarian diet in here. Where you think you are, in a hotel." We found one patient on a bed semi-conscious and observed two members of staff taking a blood test. One member of staff was holding her arm down while the other took the blood. Staff did not give reason as to why one member of staff was holding the patient's hand down.
- The hospital scored lower than the England average in the 'patient led assessment of the care environment' (PLACE), 'privacy, dignity and wellbeing' category in 2015. The hospital score was 82%, the England average was 86%.

Understanding and involvement of patients and those close to them

- The hospital scored 80% in the NCDH key performance indicator two (KP2) for documented evidence that health professionals had discussed the patient would probably die in the coming hours or days with families. This was slightly better than the England average of 79%. The hospital also met KPI seven (KP7), above 80%, for seeking the views of bereaved relatives or friends between 1 April 2014 and 31 March 2015.
- The trust was rated in the bottom 20% of trusts in 24 of the 35 question in the Cancer Patient Experience Survey (CPES) 2015. The trust was rated the same as the middle 60% of trusts in 11 of the 35 questions. This included: "patient given choice of different types of treatment," and "possible side effects of treatment given in an understandable way."
- Staff told us they would review patients daily. Part of this daily review would be to check whether the patient had been asked whether they would like to have a bath or a general wash. During our unannounced inspection we checked the notes of three such patients whose notes highlighted that they had been offered that choice. We found these patients in unkempt state with wearing dirty and stained clothing. When we spoke with them they told us they had not been offered that choice.
- Patients' records had a section for staff to record patient discussions and involvement. Patients' preferences and wishes were also recorded. In the previous case of patient whose required vegetarian food, this information was duly noted yet no action had been taken. We have also highlighted how stronger medicine for effective pain management had been prescribed but not offered to the patient even after an assessment of the severity of their pain.
- The Bereavement Office is being refurbished at present. However, neither relatives nor staff who work in the office had been consulted on the changes that were being made.

Emotional Support

- HPCT assessments documented patients psychological and spiritual support needs as part of their holistic needs assessment.
- There was little emotional support to patients and relatives who did not speak English. Besides asking one of the volunteer chaplains from the black and ethnic

End of life care

minority to handle such cases, there were no systems in place to help them. During our inspection, we observed an agitated relative who spoke no English crying outside a ward. Members of staff who worked on the ward were coming in and out of the ward and saw this relative. Not one member of staff stopped to ask how they could help. A member of the family who also did not speak English came and escorted the family away.

- The hospital had one whole time equivalent chaplain. There were a number of volunteer chaplains from other faiths. Chaplaincy staff told us that due to their numbers, ward staff involved them almost at the end of people's lives. We have previously highlighted how the arrival of the chaplain on the ward was perceived by patients and relatives. Therefore, ward staff were left to provide the emotional support. With a high number of agency staff covering wards, there was little evidence to suggest patients received this support.

Are end of life care services responsive?

Requires improvement



We rated responsive as requires improvement because;

- The needs and preferences of patients and their relatives were not central to the planning and delivery of care at this hospital.
- There was limited data to suggest those patients in the last days or hours of life were in their preferred place of care.
- Learning from complaints was not shared at team meetings.

However,

- There had been "deep dive" into end of life care that had identified six areas of improvement that had now become part of the site improvement dashboard.
- The hospital had dedicated end of life care beds.
- The hospital delivered patient centred care in a timely way. Most patients were reviewed by the hospital palliative care team within 24 hours of a consultant referral. Ward staff found the hospital palliative team to be helpful, supportive and responsive to the needs of patients.

- There was open access for relatives visiting patients who were dying.
- The hospital operated a rapid discharge home to die pathway which served to discharge a dying patient who expressed wanting to die at home within 24 hours. We did not see any audits to evidence this.

Service planning and delivery to meet the needs of local people

- The trust had a draft strategy for end of life care. However, managers told us this could only be implemented if the HCPC had increased staffing levels. The HCPT had produced a detailed business case for increased staffing in the HCPT. The draft business plan was in the process of being submitted to the trust board for consideration. However, bereaved relatives had not been engaged in the drafting of the strategy. Front line staff we spoke with were not aware of this strategy. Staff we spoke no engagement had been undertaken of bereaved relatives. Heads of other services that had redesigned their service to meet the needs of end of life care patients were not aware of the strategy. For example, the head of therapy service, had recently (June 2016) redesigned the band 7 occupational therapy role so as to ensure that all grades of occupational therapy staff gain experience and were supported in the assessment and management of individual needs with limiting conditions. This new role would contribute to the quality of care of end of life care patients. However, this new role did not feature in the trust's overall strategy for end of life care.
- The hospital had completed a 'deep dive' in EoLC in March 2016. As a result the hospital had introduced a number of improvement projects, including: a site improvement dashboard which was red, amber, green (RAG) rated. The dashboard identified areas for improvement. One of the areas for improvement included teaching on the compassionate care plan.
- The hospital did have dedicated end of life care beds. The Margaret centre was an 11 bedded palliative care ward.
- Patients identified as being in the last days or hours of life were mainly nursed on general medical and surgical wards. Nursing staff, we spoke with told us those patients recognised as being in the last hours or days of life were, where possible, nursed in a side room to protect their privacy and dignity. When we asked to see what a side room would look like, we found that it

End of life care

would have up to four people in it. In the recent Deteriorating Patient Improvement Group (DPIG) minutes of June 2016, 40% of the wards had identified a “quiet space.” However, a walk around, (the minutes did not identify by whom), revealed that many of these areas were not up to standard (B and C block in particular). The action from this was discussions were to be had with the estates department. The outcome of what actions the hospital has taken were not available from the minutes. They were provided only when this gap had been identified in the minutes. The following action had been taken including a new quiet room to support Conifer and Cedar wards, a new patient room was planned for Chestnut ward and the remaining quiet rooms that have been identified as requiring redecoration will be addressed a part of the 2016/17 backlog maintenance allocation.

- Information about the numbers of referral and re referrals of all patients and those with non-malignant disease were collected monthly, this showed an increasing number of non-cancer patients referred to the service.

Meeting people’s individual needs

- The needs and preferences of patients and their relatives were not central to the planning and delivery of care at this hospital. For example, no action had been taken to ensure appropriate quiet space area had been created once it was identified that these areas were not up to the standard. Minutes of the DPIG June 2016 highlighted that there were 13 end of life care related incidents in May 2016 that were pressure ulcer related. The minutes do not highlight the action(s) taken by the hospital as a result of this audit.
- During our inspection of medical notes and care plans, we found that there was very limited documentation on dementia assessments. This meant staff could not respond to an individual’s needs based on thorough assessment.
- There was no system for staff to fast-track patients who were close to the end of life from the hospital’s A&E up to wards that could provide appropriate care more effectively.
- Translation and interpreter services were available and staff knew how to access this when needed. Patients and relatives whose first language was not English told

us they had to rely on family members to translate and interpret. However, staff told us staff who spoke languages would be approached first if an interpreter was required.

- The hospital had electronic flagging on the patient administration system so that patients with a learning disability could be identified. Staff were unable to highlight examples of what reasonable adjustments were made for patients with a learning disability.
- Staff on the wards explained the procedures following the death of a patient. We were shown the necessary documentation and wrist bands. Body bags and shrouds were also available on the wards.
- The mortuary service had a viewing suite where families could visit their relatives. We visited the area and saw that the viewing suite. The suite was clean and provided seating. The mortuary staff supported the families during the viewing. Prior to the viewing, they ensured relatives knew what to expect. There were also arrangements in place to support families out of hours.
- Relatives told us they could visit the ward at any time when their loved ones were approaching the end of life. Relatives were supported with refreshments.
- The chaplaincy offered a reactive service. It played a part in the delivery of end of life care with specialist palliative team at the Margaret Centre. For example, it attended the multidisciplinary team meeting for palliative care every week to discuss end of life care patients.
- However, its visibility on the wards was poor because of the low numbers. Relatives told us it was so rare for the chaplain to be seen on the wards that when they did come, it was assumed that the patient was about to die and they had come to give them the last rites.
- The chaplain told us that when patients or relatives had requested faith leaders from other religious denominations, this would be arranged by the chaplaincy service. The department also received ward visitation and Holy Communion support from the local Roman Catholic Church.
- The hospital had taken some action as a result of the NHS Chaplaincy Guidelines 2015, Promoting Excellence in Pastoral, Spiritual and Religious Care. We asked for it during the announced inspection in July and the unannounced inspection in August 2016. We did not receive this information until the report was sent to the

End of life care

trust for factual accuracy in December 2016. According to the submission made by the trust in December 2016, a baseline assessment was undertaken regarding chaplains per bed ratio. The guidelines were reviewed by the head of chaplaincy. We are unable to verify these numbers. The trust has now started to provide pastoral care as part of the end of life care strategy at Whipps Cross University Hospital.

- The multi-faith chapel, for patients, relatives and staff was clean. There was a Muslim prayer room with adequate washing facilities available. However, female Muslim members of staff told us that the space available for them to be part of the Friday prayers was limited to six female staff members. This had been previously raised by Muslim female staff members (January 2016) but no action had been taken.
- There was a body storage area, which was well maintained and dignified. A Monday to Friday and out of hours service were provided. Out of hours involved the mortuary staff assisting the families with the viewing process.
- The bereavement services, worked alongside mortuary services, the coroner's office and the registrars to ensure arrangements were in place after death. They provided information to relatives and booklets around services available at the hospital, and for coordinating arrangements to view the deceased's body.
- The bereavement officer would meet with bereaved families to arrange collection of the patient's death certificate in addition to arranging a viewing at the mortuary if required. Where post mortem arrangements were in place this would be explained to the family.

Access and flow

- All of the hospital's information leaflets informed patients that the leaflets were available in other languages.
- The hospital operated a rapid discharge home to die (RDHD) pathway for patients who were thought to be in their last days of life and had requested to die at home. The pathway included a comprehensive list of actions, which ensured that a patient could be discharged home in a safe and timely manner, and included liaison with primary care, voluntary sector services and relatives.

The pathway aimed to discharge patients' home within 24 hours. During our unannounced inspection, we found two patients who were unable to be discharged to die at home due to delays in arranging care packages.

- There were no audits to monitor if patients were discharged within 24 hours when requested.
- The hospital palliative care team told us patients would be formally referred to the service by the team's telephone referral line; this was administered by the team's reception staff. Referral guidelines for the HPCT team were available on all the hospital wards and the hospital's intranet. The HPCT team told us they also received verbal referrals from both medical and nursing staff on the wards or from community palliative care teams, whose patients had been admitted to hospital.
- Staff at the bereavement office told us the wards were responsive to informing the office of deceased patients with religious needs that needed to be acted on quickly. We spoke to a Jewish family who told us they were well supported during a recent death of a friend at the hospital. A Muslim family highlighted how the hospital were responsive to the religious needs of the deceased. They shared their recent experience of a relative who passed away in the hospital.

Learning from complaints and concerns

- The hospital was unable to provide data on complaints related to end of life care. Learning from incidents related to end of life were presented at the daily safety huddles they took place. However, how the learning from those incidents were going to be cascaded across the hospital was not clear. We attended one such safety huddle where an incident related to end of life care was highlighted. There was no follow up of how the learning from this incident was going to be cascaded across the unit. A senior nurse informed us that while the daily safety huddle was a new initiative, there were issues such as the sharing of the learning across the hospital to be completely ironed out.
- We saw Patient Advice and Liaison Service (PALS) leaflets available around the hospital.
- Staff in the bereavement office told us that they try to resolve any concerns from relatives in a timely way to avoid escalation to a formal complaint. .

End of life care

Are end of life care services well-led?

Requires improvement



We rated well-led as requires improvement because;

- While the trust had developed a draft strategy for the end of life, it had not linked it with other services such as therapy services.
- The hospital had not taken the opportunity to change the culture of the organisation by making end of life care training mandatory for their consultants.

However;

- Senior managers and the chief nursing officer (CMO) understood the risks and challenges to the service.
- There was a system of governance and risk management meetings at both departmental and divisional levels.
- Linking the end of life care to the Deteriorating Patient Improvement Group (DPIG) had engaged clinical colleagues.

Leadership of the service

- The trust's chief medical officer (CMO) was the board member with specific responsibility for care of the dying. Staff at the HPCT told us that the appointment of a board member for EoLC had been a positive development for the service. Staff said the appointment of the CMO had increased the profile of EoLC at board level. However, throughout the inspection, the team heard the importance of culture within the organisation to bring progress to this agenda. The leadership team leading on end life care stressed how the culture of the organisation was changing to respond positively to the delivery of end of life care. However, we noted two important issues that highlighted the inauthenticity of this statement: The trust board had yet (September 2016) to have a board seminar on end of life care. The business case for £1.5 million to improve EoLC was being presented to the board for its approval without providing the board with a board seminar to inform them of this area. Secondly, throughout the inspection we heard the importance of training all staff on end of life care. The importance of training consultants in this

area was mentioned by a number of people. Yet, despite the importance of this training for consultants being highlighted as one of the key recommendation by the National Care of the Dying Audit in May 2015, the trust had not taken the opportunity to change the culture of the organisation by making this mandatory for their consultants.

- There was a clear governance structure and lines of accountability for EoLC. We viewed a EoLC management and governance flowchart which clearly detailed how the Whipps Cross University Hospital task and finish group fed into the trust's EoLC steering group, which reported to the trust board.
- Some staff at the HPCT team told us they had received, "excellent leadership," from trust's lead nurse for palliative care. However, staff said the trust's lead nurse was on a temporary contract and said they were worried that the lead nurse for palliative care would not be offered a permanent contract.
- Staff on the wards told us senior management and executives were, "more visible." However, a few staff told us there had been a lot of management changes and it was not always clear who managers were.

Vision and strategy for this service

- The trust's chief medical officer (CMO) was the executive lead at board level for EoLC. The trust had a draft strategy, 'End of Life Care Strategy 2016-2019,' which was based on the '5 priorities of care for the dying'.
- HPCT staff told us they were aware that a vision for EoLC services and a strategy of improvement and change to service delivery for EoLC was being developed. However, staff said they were unaware of what this would entail. Managers we spoke with told us there would be a period of staff consultation commencing in August 2016. However, there were no plans in place on how this consultation would take place.
- The trust had a draft business case, 'increased staffing to improve end of life care and specialist palliative care across Barts Health NHS Trust'. A programme manager had been employed to manage the planning and eventual delivery of the business case and strategy. The business case was linked to the trust's priorities, objectives and plans. However, this business case had not taken into consideration as to how other services

End of life care

such chaplaincy and therapy services would link in to the overall vision of end of life care. This highlighted that the trust had not clearly thought out how this agenda would link to all aspects of the trust work.

- The trust's values and behaviour statements were displayed on notice boards around the hospital, as well as on the trust's intranet and internet. Most staff we spoke with told us the trust's vision and strategy was publicised on the trust's intranet and on emails. Staff said they incorporated the trust's values and behaviours into their practice.

Governance, risk management and quality measurement

- Whipps Cross University hospital did not have an end of life committee. The trust had a Deteriorating Patient Improvement Group (DPIG) and the head of end of life at Whipps Cross University hospital together with a number of other stakeholders were part of this group. This has encouraged cross linkages. However, the lead for end of life care was not aware how and where issues emerging from the DPIG relating to end of life care were going to be escalated.
- There was no evidence that demonstrated the trust board saw the minutes of the DPIG.
- The HPCT had two risks identified on the trust risk register, both related to adequate numbers of staff and the potential impact staffing could have for patients. Most of the staff we spoke with were aware of the staffing risks.
- The specialist palliative care risk register was RAG rated and contained five identified risks. The risks were assessed and scored when added to the register, and assessed and scored when reviewed; the register also gave the hospital's target score for risks. There were five identified risks on the register: two of the risks had reduced and met the hospital's target: three of the risks had reduced but had not met the hospital's risk target.

Culture within the service

- All the staff we spoke with from the HPCT told us the team were supportive. Staff we spoke with told us they felt they could raise concerns with team leaders. Staff at the HCPT told us the team culture was open and honest.

- Staff at the HCPT told us they felt respected and valued by the ward staff. The quality of patient experience was seen as a priority by the SPC team.
- HCPT staff were aware of whistleblowing information and a confidential telephone service was available for staff who wished to raise concerns.
- Staff at the HPCT told us morale in the team and across the hospital had improved in the past 12 months. Staff said the hospital had launched 'listening into action' events. These were groups staff could attend to speak with senior manager or board members about services at the hospital.
- The staff we spoke with told us the HCPT team worked collaboratively with staff on the wards in providing EoLC. The HPCT told us ward staff worked constructively with the team. Across the wards we visited, we saw that the HPCT worked well together with both the ward nursing and medical staff.

Public and staff engagement

- The public were involved in patient led assessments of the care environment (PLACE) in July 2015. In response the hospital had produced a, "you said, we did", report addressing all the issues the PLACE assessment had raised. For example, marks on doors on the wards were escalated to the domestic services supervisor.
- Staff we spoke with told us they had not been engaged with the EoLC strategy. However, managers told us the ratification of the new strategy had been delayed whilst staff feedback was obtained. The staff consultation was due to commence in August 2016. The engagement of bereaved families regarding the strategy had not been considered by the hospital.
- However, there was an instance where staff were not consulted. Changes had been made to the bereavement office and staff from that department had not been consulted.





Innovation, improvement and sustainability

- The CMO had a particular interest in EoLC for patients with kidney disease. The CMO arranged an annual bereavement conference at the trust. The 2016 conference had a number of invited speakers that were specialists in palliative and EoLC.

End of life care

- The hospital was involved in a guide describing clinical signs that can help the hospital identify patients who are deteriorating and dying from one or more advanced conditions. When this guide is implemented, it would improve the quality of the interventions made by the hospital for end of life care patients.
- The end of life care committee was joined with the “Deteriorating Patient Improvement Group”, it had engaged clinicians. It had enabled other responsible people across the hospital to "own the agenda" rather than it being the sole responsibility of the end of life care committee.

Outpatients and diagnostic imaging

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

Information about the service

Whipps Cross University Hospital provides a full range of outpatient services. The services include urology, ENT (ear nose and throat), audiology, cardiology, colorectal surgery, and cancer care.

Between January and December 2015 there were 481,011 hospital outpatient appointments at Whipps Cross University Hospital.

We visited the general outpatient area at Whipps Cross University Hospital including radiology and diagnostic services, ophthalmology, orthopaedics and phlebotomy. We spoke with 30 patients and their relatives and 69 staff, including consultants, managers, nurses, healthcare assistants, allied healthcare professionals and medical and reception staff. We observed care and treatment, and looked at records. During our inspection, we reviewed performance information from, and about, the hospital.

Summary of findings

Overall we rated this service as inadequate because:

- Incidents were not always reported or actioned in line with trust policy. Staff and managers had different views on what should be reported and what actions should be taken when incidents were reported. The trust had identified capability issues with staff using the incident reporting system without sufficient understanding of risk assessment and governance awareness as an issue. This was not on the risk register and robust action was not being taken to ensure this was a priority for the trust.
- Risk registers did not reflect all areas of concern, for example; concerns about staffing in radiology and diagnostics were not recorded. A review of staffing had highlighted the need for six additional radiologists however funding had been refused for this financial year.
- Risks relating to radiology and diagnostic equipment breakdown were on the risk register, however there was no mention of the impact on patients when appointments were cancelled, or co-ordinated systems in place to ensure patients were appropriately re-booked. We were not assured the trust had systems and processes in place to effectively identify risks to patient care.
- Opportunities to assess, monitor or manage risk to patients and minimise harm were missed. For

Outpatients and diagnostic imaging

example, staff had reported concerns about out of hour's triage and contact arrangements in radiology and diagnostic services. It was unclear where evidence of change, analysis or discussion had taken place as a result of the incidents.

- Some services were not offering a full seven-day service. For example in computerised tomography(CT) and multi resonance imaging(MR) staffing constraints meant the service was dependent on agency staff and permanent staff volunteering to cover weekend out of hours shifts. This limited the responsiveness and effectiveness of the service the hospital was able to offer. We saw several incidents reported where clinicians and the radiographer had been unable to contact the out of hour's on-call agency radiologist for advice as they had not answered the phone.
- The trust had a duty of candour (DOC) policy and kept appropriate records of incidents that had triggered a DOC response, however most staff we spoke with did not understand their responsibilities around DOC.
- The outpatient department was not tracking all patient health records. This had been considered during the redesigning of the service however resources were unavailable. The location of medical records was often unknown and resulted in delays or temporary notes being used. Trusts have a responsibility to track all patients' health records (Records Management: NHS Code of Practice Part 2, 2nd Edition, and January 2009).
- Systems for monitoring the quality of services and risks associated with delivering services were not always effective. For example, staff did not always have the complete information they needed before providing care and treatment. Staff making up temporary records often had to source information about a patient's care and treatment before the patient could be seen. They were reliant on information on the patient's electronic record. Most referrals were paper and were scanned onto the system in the appointment centre. Delays in scanning referrals and triaging of referrals meant current information might not be available. Examples

were given to us by staff where patient referral information was not in the file and in some cases this amounted to no more than a front sheet detailing patient's personal information. Improvements had been made to data collection systems but outcomes for patient's care and treatment was not always monitored regularly or robustly. This meant monitoring was not always used effectively to improve quality.

- The implementation of a centralised appointments booking system for outpatient appointments had not gone smoothly and had caused problems for patients and staff. These included late notice of appointments, repeated cancellations of appointments and clinics and delays in dealing with urgent referrals. There was no clinical review of the patients affected when a clinic or appointment was cancelled and there was potential for people who needed urgent appointments because of their condition to have delays that affected the timeliness of their condition being diagnosed or treated.
- The appointment centre and central booking call centre had a shortage of skilled staff and operating systems that were not working effectively for patients. As a result, patients and staff were often unable to contact the call centre when they needed to. The trust were monitoring the performance however they did not have a comprehensive action plan in place to ensure action was taken to minimise the time people had to wait for treatment or care.
- There were data quality concerns relating to the accuracy, completeness and consistency of the referral to treat (RTT) patient tracking list. There were booking slot issues seen in dermatology, gastroenterology, ophthalmology, trauma and orthopaedics (T&O) and urology. These meant patients were not allocated appointments within the appropriate timescale because there were none available. Managers told us clinicians made the decision to put on additional clinics however this was dependent on them finding suitable clinic space and having enough nurses and consultants available. This meant RTT data provided by the trust may be incomplete and therefore inaccurate.

Outpatients and diagnostic imaging

- The trust did not have a robust enough system of audit in place or effective enough means for measuring quality. Reporting turnaround times in radiology and diagnostics were not meeting best practice guidance. Over 25% of radiology and diagnostics patients had not had scans or x-rays reported on within the recommended timescales. Service delivery and improvement were sometimes reactive and improvements were not always identified or action taken. This meant the impact on the quality of care for patients was not always effectively monitored and risks and issues were not always dealt with in a timely way or appropriately.
- We received a number of comments from staff reporting a culture of bullying and harassment. The trust performed worse than the national average (combined trusts) in 26 of the 32 key findings in the 2015 NHS Staff Survey. For example: 47% of staff recommended the trust as a place to work which was worse than the England average of 58%. 37% of staff experienced harassment, bullying or abuse from staff in last 12 months which was worse than the England average of 24%.
- We observed a lack of leadership which led to some staff feeling demotivated, high levels of stress and work overload. This resulted in poor cooperation between teams and staff reluctant to raise concerns. 21% of staff felt they had experienced discrimination at work in last 12 months which was worse than the England average of 10%. Staff reported that inconsistent application of human resource policies and advice contributed to inequality and division within the workforce and led to a lack of performance and behaviour management within the organisation. These were similar issues to those found during the last inspection.
- The trust had a vision and strategy which some staff did not feel they were part of. There was a lack of cohesive strategy for outpatient's services. Whilst there were governance systems in place they were complex and mostly operating in silos. Senior managers had started to co-ordinate more joined up working, however this was not translated into actions at operational level. This meant there was little

cross-directorate working, few standard practices and ineffective leadership. Not all leaders had the necessary experience, knowledge, capacity to lead effectively.

However:

- We saw that records were securely stored.
- Medications that were prescribed were managed safely. In outpatients, radiology medicines were stored in locked cupboards in the department. Lockable medicines fridges were in place, with daily temperature checks recorded.
- Staff were aware of their roles and responsibilities with respect to safeguarding and knew how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- Patients received a caring service and staff promoted the privacy and dignity of patients. Most patients and relatives were happy with the service and we observed staff to be caring and compassionate in the areas we visited. Patients we spoke with told us that staff were kind and helpful and treated them with respect. Most patients and relatives felt involved and included in discussions about their care and treatment.
- Staff could access translation services, with patient literature available in some languages and in accessible formats. Staff had a good understanding of the different cultural needs and backgrounds of patients and staff.
- There was evidence of treatment across outpatient's services that were delivered in line with national guidance and best practice. Staff had access to provision of evidence-based advice, information and guidance. Staff with specialist skills and knowledge supported their colleagues to provide advice or direct support in planning or implementing care. Teams made appropriate referrals on to specialised services to ensure that patients' needs were met.
- Managers and staff reported that support from the trust's HR department in dealing with staff disciplinary and capability issues had been variable.

Outpatients and diagnostic imaging

Several staff commented that there had been an improvement in the level of support over the past few months however it had not been effective in dealing with the issues.

- Most staff felt there had been an improvement in communication from the senior leadership team and were positive that the trust were heading in the right direction to improve patients experience.

Are outpatient and diagnostic imaging services safe?

Requires improvement



We rated safe as requires improvement because:

- There was a system for reporting incidents but it was not always used. Staff were not clear about what should be reported as an incident and incidents were not always reported or actioned in line with trust policy. We saw that the learning from incidents was inconsistent across the different specialities and incidents were not shared across the outpatient department as a whole.
- In radiology and diagnostics the CT scanners and MRI were on the risk register because they kept breaking down or were unable to be used appropriately. This meant patient appointments were cancelled and the trust did not check whether delays caused any potential harm to patients.
- There were problems with access to information as patient's full medical record was not always available.

However:

- There were safeguarding policies in place and clear procedures to follow if staff had concerns. Staff were aware of their roles and responsibilities and knew how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
- There were good standards of infection control and processes were in place to make sure infection control risks were reduced.

Incidents

- There had been no never events (never events are serious incidents that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers).
- There were two serious incidents (SI) requiring investigation reported in the outpatients department. One was a diagnostic incident including delay meeting SI criteria (failure to act on test results). The other was a radiation incident.

Outpatients and diagnostic imaging

- The outpatients department used the trust's electronic reporting system called 'Datix' to record incidents; however we found that Incidents were not always reported in line with trust policy. For example, staff told us clinics often ran late and they should report these. Some staff told us they always reported these and other staff said they did not. Several staff said that clinics were very busy and this meant they did not have the time to complete incident reports as had to prepare for the next clinic.
- We found staff had different views on what constituted an incident and needed to be reported. Most staff were clear about performance data that needed to be reported. For example, staff knew to report cancelled clinics but were not clear about what constituted an incident. Some staff did not know if there was a policy on incidents. The June (2016) risk management committee minutes identified "capability issues with staff using Datix without sufficient understanding of risk assessment and governance awareness" as an issue.
- For example; information provided by the trust recorded that between July 2015 and July 2016 the MRI scanner had broken down 18 times. On the majority of occasions the scanner was out of use for a minimum of 30 mins to a maximum of four days over the 18 recorded occasions. None of these occasions were reported as an incident or recorded on a datix.
- The trust did not check whether delays caused any potential harm to patients. They told us if there was any potential harm it would be recorded as an incident on datix. This meant they were reliant on staff reporting incidents and would not know about possible risk or harm until after the risk of harm had been reported.
- We found that reporting incidents did not mean learning always took place. For example; there was no provision for out of hour's ultrasound, as at the weekend radiology services primarily covered inpatients. GP's that required urgent out of hours scans sent through referrals to the hospital. We saw that an urgent request for ultrasound (USS) had been received on a Friday evening but had not been actioned until the Monday. The datix report stated the member of staff had been unable to place the level of harm, as the USS was urgent. The patient had been at home and at risk of a deep vein thrombosis and bleeding due to anticoagulant treatment. This meant the USS had been essential to determine the course of treatment. The incident outcome had been recorded as "no harm" but the outcome could have been very serious. It was unclear what changes had been put in place to minimise risks to patients. Risk assessments had not been completed to ensure future urgent GP referrals were triaged and ensure they were risk assessed appropriately.
- Urgent patients that were not inpatients were not routinely scanned, however staff said that if the GP discussed with sonographer or nurse, staff would try to scan urgent patients. The GP had tried to telephone to department but could not get through as ultrasound staff were not answering the phones.
- We saw other examples where it was unclear how lessons were learned and action taken when incidents did not progress to full investigation. The decision maker was the relevant manager for that service and it was not clear what processes were in place to quality check decisions made by individual managers to ensure they were following trust policy.
- In radiology and diagnostics the CT scanners and MRI were on the risk register because they kept breaking down or were unable to be used appropriately. This meant patient appointments were cancelled and the trust did not have effective systems in place to check whether delays caused any potential harm to patients.
- Nursing outpatient managers held weekly meetings to discuss any issues including any incidents in outpatients. In radiology and diagnostics staff told us about two examples where learning, changes to processes and additional training had been made to maintenance of scopes in endoscopy.

Duty of Candour

- The chief medical officer (CMO) and chief nurse (CN) reviewed all serious incidents (SI) and completed SI root cause analysis reports for compliance with their Duty of Candour policy. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- The trust board performance report for June 2016 stated "performance declined to 46% in April 2016 from 54% in March 2016. Weekly governance meetings took place to review all serious incidents and complaints. The

Outpatients and diagnostic imaging

performance reported was not in line with practice at other trusts and the trust were reviewing the data as part of the trusts data quality review as managers felt it under reported compliance. A clinical director had been appointed to provide leadership for WCUH over the next three months with the aim of delivering 100% performance by 31 July 2016.

- Most nursing staff we spoke with were not clear what duty of candour meant for them in their role. Two managers accurately explained what responsibilities they had under duty of candour.
- Staff in x-ray told they had just been given leaflets about duty of candour and had discussed it in their recent staff meeting.

Cleanliness, infection control and hygiene

- The lead nurse took responsibility for monitoring the trust policy on hand washing and took responsibility for training staff. Specific performance information relating to outpatients departments was unavailable.
 - Staff told us that they received mandatory training in amongst other things infection prevention and control training.
 - Clinical areas appeared clean and there were systems to monitor checks of cleanliness. Spillage and cleaning products were available to staff.
 - We observed that staff complied with the trust policy of being bare below the elbow and wearing minimal jewellery. Hand gel was available in clinical areas.
 - We saw regular hand hygiene audits that confirmed staff were compliant with legislation.
 - We observed staff in the eye clinic following infection control processes as they treated patients.
 - There were systems in place for the segregation and correct disposal of waste materials such as x-ray solutions and sharp items. Sharps containers for the safe disposal of used needles were available in each clinical area. These were dated and were not overfilled. Notices were displayed in clinical areas explaining the actions staff should take in the event of an injury from a needle.
- reported by them on multiple occasions and had not worked for the past year. On the day of our visit portable fans were in use in the department. Patients and staff told us these were new and had only just been put in place.
 - Staff gave us examples where in cold weather the temperature in the waiting room had been extremely cold and clinics had been cancelled.
 - In outpatients we observed water was leaking from a water machine and had been leaking for the last two weeks. The leak had been reported the leak to the external supplier, who had visited and were waiting for a new part. In the meantime it was still in use and continued to leak over the corridor and across the entrance to a toilet. I asked the nurse who was responsible for checking and wiping up the water spillage. The manager said it was “everyone’s” responsibility. I asked two staff if they knew about the water leaking and they said they did not. This meant patients could be at risk of harm from slips and falls as there was no one responsible for making regular checks to ensure the water leak was kept under control and floors safe for patients to use.
 - In radiology and diagnostics the CT scanners and MRI were on the risk register because they kept breaking down or were unable to be used appropriately as they were not accurate enough. For example, both computerised tomography (CT) scanners; CT2 and CT3 were on the risk register and had broken down regularly for differing periods of time. In some cases for two or three days at a time. A plan to replace one CT scanner was in place for the next financial year.
 - Staff told us they had lots of “old equipment” that affected the amount of time it took to complete an examination and they were limited in what they could use some equipment for. For example, one ultrasound could only be used for gynaecological examinations as it was not reliable for anything else. The limitations and breakdowns in equipment put additional pressures on staff.
 - Staff told us cancelled patients were booked as soon as slots were available however it was often dependent on whether radiographers agreed to volunteer to work and cover additional lists at the weekend. The trust did not collect information on how many patients were cancelled due to equipment breakdowns. This meant they did not know the impact for patients or how long individual patients had to wait for their treatment.

Environment and equipment

- Staff told us maintenance was a problem and it could take a long time to get things put right. For example, the temperature control system in the main ophthalmology waiting room did not work. Staff told us it had been

Outpatients and diagnostic imaging

- The Radiology department provided personal protective equipment for staff (PPE) .for example, lead gowns, which protected staff from the effects of radiation. We found that maintenance records were not available to confirm that equipment was safe for staff to use. For example to check for damage such as cracks or splits that could let in radiation. Staff could not tell us when equipment was last checked. This meant the trust could not evidence they were following the Health and Safety executive(HSE) working with ionising radiation guidance that stated “every radiation employer shall ensure that all personal protective equipment,...is, where appropriate, thoroughly examined at suitable intervals and is properly maintained.
- Equipment we looked at was visibly clean and stored appropriately. The trust used the “I am clean” stickers to identify clean equipment. We observed stickers on equipment in different outpatient areas that identified they were clean.
- We observed all electronic equipment had been safety tested to ensure they were compliant with portable appliance (PAT) testing regulations.
- Radiographers showed us the procedure for eliminating exposure to radiation and the personal protective equipment in place for staff to use.
- We observed that staff regularly checked resus trolleys. All those we checked were well maintained with relevant medication in date. Resuscitation trolleys were available within the radiology department and were checked and maintained ready for use in an emergency.
- Medication training was provided by the trust and competency frameworks were in place to ensure staff were compliant with trust policy.
- Emergency medication and emergency equipment was available on resuscitation trolleys. These were recorded as being checked daily. Emergency drugs were checked and in date.
- Allergies information was checked as part of agreement to use a contrast media for a procedure.
- The radiology department used patient group directives (PGD) for contrast media and bowel preparation for pneumocolon(examination of the large bowel). We found these were all in date, signed off and competency assessments had been completed for radiographers to demonstrate their understanding.

Records

- Staff told us secretaries held onto patient’s records across most specialties to type letters to inform patients of their results. Delays in reporting on radiology and diagnostics investigations could mean that patient records were not updated or returned to records department when they should be and could be missing for several months. Staff said that if patients had other appointments within that time period their records may not be available as they would be kept with the relevant speciality. For example in the eye clinic one member of staff said notes “were often incomplete or missing up to date information”. The health records department had sent out a newsletter in March 2016 offering an amnesty to staff to try and get records returned and had some success. It listed some of the reasons staff held onto records including staff holding onto notes for future appointment and keeping if there were typing backlogs.
- If records were not returned then we were told by staff records management staff would make up a temporary file and print off available information on the electronic record. This could mean appointments would take place without all the relevant information that might be important for their care or treatment.
- There was a team in place to reunite temporary notes with the original notes. Notes were collected from clinics and we were told that if the original notes turned up then they should be joined together but this was not audited or monitored to ensure this happened.

Medicines

- We saw evidence that staff managed prescribed medications safely. In outpatients, radiology medicines were stored in locked cupboards in the department. Lockable medicines fridges were in place, with daily temperature checks. This meant that the department were following the appropriate guidance on the safe handling and storage of medication. However we found that storage of gastrografin (is a palatable lemon-flavored water-soluble iodinated radiopaque contrast medium for oral or rectal administration only) in GP X-ray was in a very hot room. The temperature was not being monitored and should have been less than 25 degrees. Because it was not monitored we could not be assured it was within the required temperature zone for safe storage. This was reported to staff on the day.

Outpatients and diagnostic imaging

- Staff told us they were reliant on individual specialities making sure notes were returned to records library and their focus had been on ensuring all patients had either permanent or temporary notes available for their appointment. Plans were in place to move onto the next phase of ensuring all permanent notes were tracked so they could be found when needed. Additional staff capacity was needed and plans to recruit to additional posts were in discussions however this had not yet been agreed. Some redistribution of staffing posts had taken place but no clear action plan was in place with a timescale for when this would be implemented.
 - Following the last inspection when issues had been raised about records we saw work had been done to ensure the majority of patient records were returned to the records library.
 - Data provided by the trust showed that between January and June 2016 98% of patient's permanent record were available for clinic. This meant that 2% of patients were provided with temporary notes. However the data did not make clear how current the permanent notes were, how many patients had duplicate permanent records and numbers of duplicates rather than temporary files. Several staff told us some patients had more than one set of permanent notes and it was unclear at what point a temporary record became a permanent record hence was not counted as temporary.
 - The trust had put systems in place to ensure that all patients had notes available when they attended clinic and systems were now in place to track temporary records needing to be made up. However this did not solve the inherent problems in that they did not know where missing patients records were and could not be certain patient information was accurate and up to date. We were told that most clinicians used paper notes rather than the electronic patient record when seeing patients so it was important they contained all relevant and information was current.
- Safeguarding**
- Staff compliance with safeguarding training across the trust did not meet the trust's target. Detailed information on outpatients training rates were unavailable. This meant that not all staff was adequately trained in their responsibilities for safeguarding children and vulnerable adults. An "improvement and performance framework" had been agreed for safeguarding children training with the aim of improving compliance with level 2 training in safeguarding adults.
 - Safeguarding level 1 training was included as part of the mandatory training package. All staff were required to complete the level 1 safeguarding course for children and adults every three years. This course was delivered via a booklet or as an e-learning course. Doctors, nurses and other staff members dealing directly with patients were required to complete level 2 training every three years. Staff we spoke with told us they had completed training in either safeguarding adults or children, whichever was most relevant to their area of work. Most staff could not tell us what level they had completed but understood the principles of keeping patients safe and the process for reporting. We were given examples by staff where staff had reported concerns using the safeguarding process. This meant staff were aware of their roles and responsibilities and knew how to raise and escalate concerns in relation to abuse or neglect for vulnerable adults and children.
 - We saw there were safeguarding policies in place and clear procedures to follow if staff had concerns. Staff told us they knew where to find information should they need to.
 - Information about how to report any safeguarding concerns and safeguarding adult's information was displayed in outpatient clinics.
 - The June 2016 trust board report stated that "with the exception of Level 1 safeguarding training, information governance, infection control Level 1 (all) and safeguarding children (at Whipps Cross Hospital), all sites continued to perform below the targets for statutory and mandatory training requirements". E-learning materials had been developed to meet mandatory training needs and could be accessed electronically. Subjects covered included, manual handling, safeguarding level one, equality and diversity and information governance.
 - Bart's Health provided all staff with a mandatory training book, "Your Mandatory Training Booklet" (July 2015). The booklet was 72 pages long and included a chapter on safeguarding adults(level1), There was a note at the back to say, 'It is essential that you inform your manager that you have read and understood the

Outpatients and diagnostic imaging

contents of this booklet'. Whilst the booklet emphasised the importance of reading, understanding and applying the guidance, there was no system to check staff understanding.

- In April 2016 a programme of events had begun with additional support to existing training being implemented for infection control. This was because commissioners had expressed their concern at the continued poor performance of the trust. An action plan and improvement trajectory had been submitted to commissioners. Several staff we spoke with told us managers were now actively checking staff training and they had been told they must complete their mandatory training when it was due.

Assessing and responding to patient risk

- There were systems to prioritise urgent and routine new referrals and send appointments as required to patients.
- Trust policy on ensuring patients who were unable to have an appointment booked due to capacity stated appointment slots (ASIs) should be resolved within a maximum of seven working days for urgent patients and 15 working days for routine patients. Discussions with staff and information from the trust highlighted they were not meeting this target. In some cases patients were waiting up to 52 weeks or more for a follow up appointment. The trust were aware information they were collecting was not accurate and were trying to monitor waiting lists however there was no plan in place to monitor risks to patients that were waiting long periods for follow up appointments.
- In radiology and diagnostics the waiting times for routine referrals for CT scanning was 24 days. Staff told us risk assessments were not completed to ensure the impact on patient's health and wellbeing was being monitored whilst they waited for their scans.
- There were systems to triage new referrals and send appointments to patients; however these were not always safe and effective. For example; we saw that paper referrals into the access centre were placed in trays to await triage by the clinician. We looked at one tray of over 15 referrals, one referral was dated three weeks previously and others had been waiting a week or more for triage. Staff told us they relied on clinicians

triaging referrals and if appointments were not available they sometimes went back in the trays and to the consultant until additional clinics could be put on or appointments made.

- Concerns about triage and referral processes were not on the risk register even though it was known there were delays and they were not meeting the standard operating procedure (SOP) for ASI Management.
- We observed radiology staff were not following the Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER) regulations requesting diagnostic tests. We observed staff logged into patients electronic records (PER) using one member of staffs log in and then used that log in for all requests for the day. Requester's names were recorded on the patients electronic records (PER) and could be used for audit purposes. This meant that incorrect information was being logged on the PER as the name of the original requester was not being entered on the system.
- Information leaflets and notices should be displayed to remind people of the importance of notifying the radiologist of any the associated risks including pregnancy. We saw no notices displayed that requested patients that might be pregnant to inform a member of staff, however we did observe staff verbally requesting that information before a scan. We saw that there had been incidents reported where a patient had been scanned and had not informed staff. Recommendation's included ensuring notices were visible for patients.
- There was a rapid access, walk in chest pain clinic that provided early specialist cardiology assessment for patients referred by their GP with new onset of chest pain.

Nursing staffing

- Nursing staff told us there were enough nurses to cover outpatient's clinics when everyone was at work. Agency or bank staff were used when additional cover was needed. The executive team told us that the trust was continuously recruiting nursing staff and were aiming to achieve a target of 95% of all posts across the hospital.
- Managers told us the staff complement for nurses had not changed for many years even though the workload had increased significantly. One manager said there were in the process of identifying what staff levels were needed to provide enough support to clinicians. Several staff said that when staff were on holiday or sick it

Outpatients and diagnostic imaging

became harder to manage the volume of work and they were not always able to get bank staff to cover. For example on our inspection one nurse was covering two clinics due to staff shortage. This meant they were very rushed and had to continually move between clinic spaces to manage the workload. Two nurses said most nursing staff in outpatients had been working there a long time so knew what they needed to do and covered for each other whenever they could.

Medical staffing

- Staff told us there were not enough staff in the radiology and diagnostic department to manage the volume of work. On one day of our visit the computerised tomography (CT) department was closed due to lack of staffing. This meant patients were either cancelled or appointments rearranged.
- There was a shortage of radiologists. A recent review of staffing had identified an additional six radiologists were required. A business plan had been put forward to recruit these additional staff but had been put on hold due to financial pressures across the trust. There were six agency radiographers working in the department to mitigate the vacancies.
- Radiology and diagnostics had no weekend out of hours staffing. They relied on permanent staff agreeing to cover these shifts on the bank. Staff told us agency staff were also used to cover out of hours if needed. If no cover could be arranged then patients were sent to nearest available hospital for treatment.
- The establishment for CT/MRI was three full time staff. There was only one permanent member of staff and radiographer cover via agency when it was available. Staff told us they were often understaffed which led to them feeling very pressured.
- The individual specialties and clinicians managed and arranged medical cover for their clinics. They agreed the structure of the clinics and patient numbers.
- Consultants were supported by junior colleagues in some clinics where this was appropriate. The staffing skill mix was similar to the England average for consultants, registrars and junior doctors.

Major incident awareness and training

- We identified that not all staff were aware of how to act in the event of fire. For example four staff did not know

who their fire marshal was or where to go in the case of a fire. Responses provided by nurses, healthcare assistants and administrative staff varied and did not follow the fire safety evacuation protocols.

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

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

This service was inspected but not rated. Our key findings were:

- Outcomes of patient care and treatment were not always monitored regularly or robustly. For example, staff making up temporary records often had to source information about a patient's care and treatment before the patient could be seen.
- The trust had made improvements to its data collection systems however outcomes for peoples care and treatment were not monitored regularly or robustly. This meant monitoring was not always used effectively to improve quality.

However:

- There was multidisciplinary working to provide integrated patient care. Staff worked together to meet patients' needs.
- Staff used clinical guidelines and protocols to inform their decisions about care and treatment.
- Staff gained appropriate consent for treatment.

Evidence-based care and treatment

- There was access to specialist investigations such as magnetic resonance imaging (MRI) or a computerised tomography (CT) scan. MRI is a type of scan that uses strong magnetic fields and radio waves to produce detailed images of the inside of the body whilst a CT scan uses X-rays and a computer to create detailed images of the inside of the body.
- Protocols were in place that followed national guidance for radiology examinations such as orthopaedic x-rays.

Outpatients and diagnostic imaging

- Radiation guidelines, local rules and national diagnostic reference levels (DRLs) were available for staff to access. There was an assigned radiology protection adviser and a radiology protection supervisor for each clinical area.
- The Ionising Radiation (Medical Exposure) Regulation (IRMER 2000) required doses arising from medical exposures to be kept as low as reasonably practicable. To comply with this legislation patient dose data had been collected and analysed for examinations and this information reviewed in monthly quality meetings.
- A radiation safety survey had been completed in May 2015 to ensure compliance with the Ionising Radiations Regulations 1999 (IRR99) and the Ionising Radiation (Medical Exposures) Regulations 2000 (IRMER). The staff showed good awareness of radiation protection requirements. We saw evidence through audits that radiation exposure was monitored.
- The radiation safety survey in June 2016 stated there was “a good awareness of radiation safety requirements in the department” however areas that needed attention included ensuring that personal protective equipment (PPE) checks were completed. This is equipment that will protect the user against health or safety risks at work, for example lead aprons. We had found records were not available that evidenced regular checks. This meant the trust would not have been compliant with the Ionising Radiation (Medical Exposure) Regulation (IRMER 2000). After highlighting this to the trust an action plan was put in place with targeted review dates to follow up findings and ensure staff were compliant with regulations.
- A dedicated one-stop breast clinic as recommended by national guidelines had opened in July 2016. The National Institute for Health and Care Excellence (NICE) quality standard for breast care recommended that a clinical nurse specialist is present during appointments. Staff told us this post was in the process of being recruited to. The trust had set up a patient’s forum to get first hand feedback from patients attending the breast clinic about their care and environment. We saw minutes that detailed changes made as a result of that feedback.
- There was a chronic pain and pain interventions clinic at the hospital. Patients could be referred to the pain management clinic if assessed as needing this by their consultant.
- There was also a rapid access chest pain clinic (RACPC) that provided a quick and early specialist cardiology assessment for patients with chest pain.

Patient outcomes

- The National Cancer Patient Experience Survey 2015 for Bart’s Health NHS Trust highlighted an improvement in ratings from 2014. Patients asked to rate their care on scale of zero (very poor) to 10 (very good); respondents gave an average rating of 8.4%. However, 56% of patients thought the length of time for attending clinics and appointments was right. This was worse than the national average of 66%.
- 77% of respondents said that they were definitely involved as much as they wanted to be in decisions about their care and treatment which had increased from 65% in 2014.
- When asked how easy or difficult it had been to contact their clinical nurse specialist 84% of respondents said that it had been ‘quite easy’ or ‘very easy’.
- 90% of respondents said that hospital staff told them who to contact if they were worried about their condition or treatment after they left hospital.
- 60% of patients thought they were given practical advice and support in dealing with side effects of treatment which was lower than the national average of 66%.
- Policies were in place to ensure patients were not discriminated against. Staff we spoke with were aware of these policies and gave us examples of how they followed this guidance when delivering care and treatment for patients.
- We saw audit information that demonstrated the radiology department regularly audited diagnostic reference levels in radiology and diagnostic services.

Competent staff

Pain relief

- Pain relief could be prescribed within the outpatient’s department and then dispensed by the pharmacy department.

Outpatients and diagnostic imaging

- Staff in radiology and diagnostics told us that lack of training in interventional radiotherapy (IR) had led to a serious incident. Training and regular monitoring of staff competency had been put in place as a result of the incident.
- Managers confirmed all radiology staff were up to date with IRMER training regulations.
- Concerns were raised by staff about the competency of some agency staff. Incidents reported in radiology and diagnostics identified various issues, for example staff not knowing who to contact in some instances for advice and support out of hours, or the designated person not being contactable or not responding with the advice expected by staff. Leading to delays in providing the service to patients whilst the right information was sources.
- We spoke with a selection of staff across outpatient clinics who told us they participated in the annual trust appraisal. Trust wide data showed completed appraisal performance for medical staff was 88% in April 2016, against a target of 90%. However specific information on appraisal rates for outpatient's specialities were not available. The radiology manager told us all radiology staff had had an appraisal. We did not see records that confirmed this.
- Staff in radiology and diagnostics told us all staff had a comprehensive induction. This included mandatory training. For example, infection control and manual handling.
- Nursing staff told us there was a competency framework for new staff to the service. This was monitored by managers through regular one to ones within the first 3-6 months.
- Staff told us the trust encouraged staff training, however it was mostly done online using e-learning tools or via a booklet. Statutory and mandatory training booklets were sent to all trainees on their induction day. Many staff said they did not feel this was effective for all courses, for example mental capacity act training. Several staff felt face- to- face training was better as they could ask questions at the time. Some staff told us that having the time to access e-learning training could be a problem due to workload pressures.
- The trust highlighted concerns that staff were failing to read the mandatory training booklets. These were meant to be checked and signed off by managers. Two staff told us their record had never been checked by their managers.
- Several administrative staff told us they did not have regular team meetings where they could express their views and share learning and experiences. Three staff in different departments told us the meetings they had were all about how they had performed and what they needed to do to improve.
- The trust had developed career pathways for health care assistants and nurses that was linked to appraisals. They wanted to create "skilled and empowered" nurses. Managers told us the hospital had in the past "missed out on improvements both to its environment and the opportunities for staff to develop". Staff confirmed there were opportunities to develop additional skills and knowledge and they could access it if it had been identified as part of their appraisal.

Multidisciplinary working

- Staff worked together in a multidisciplinary environment to meet patient's needs.
- All respiratory functions were delivered in a "one stop" clinic apart from x-ray.
- Multidisciplinary meetings were held after one- stop cancer (breast) clinics to discuss patient's diagnosis and treatment plans.
- Management re-structure changes meant that an outpatient's matron was now based in WCUH part time. Staff said this was a positive change and they hoped it would lead to closer working relationships to enable more joined up working in the OPD.

Seven-day services

- The outpatients department was open from 8.30am to 5pm, Monday to Friday. However, additional extra clinics could be scheduled in the evening and at weekends to meet the needs of the local population. These were mainly staffed by current trust staff working additional hours.
- Occasional evening and Saturday morning clinics were organised in the main outpatients to minimise waiting times. We noted that these were not held often enough to reduce a backlog and prevent the risk of breaching the RTT timeframe.

Outpatients and diagnostic imaging

- The phlebotomy service was available Monday to Friday 8am to 4.30pm. There was no out of hour's service.
- Radiology and diagnostics had no dedicated out of hours staffing. Staffing of all out of hours was reliant on individual staff agreeing to work and agency staffing. The radiography department staffed the x-ray department 24 hours a day to provide an emergency out of hour's service.
- There was access to specialist investigations such as MRI and CT scans or to a radiologist to interpret scans out of hours. However incident reports highlighted problems contacting the on call radiologist for information or advice. Plain film and CT services were available out of hours for emergency, in patients and theatres.
- The ophthalmology service ran an on call 'casualty service' during the evening and at the weekend where staff were available. They took referrals from the emergency department, GPs and opticians. They also provided a walk-in service during daytime clinic hours.
- We observed radiographers following the trust policy on consent. Radiographers followed the trust policy on consent to ensure that patient consent was gained for each scan or procedure. We observed staff following this policy as they gained consent from patients. We compared the practice we saw with the Society and College of Radiographers' recommendations and saw that the department's practice was in line with professional guidance.
- Staff told us that doctors discussed treatment options during the consultation. Where written consent was required, this would often be obtained in the outpatient clinic. Patients told us they had been asked for consent before their procedures.

Are outpatient and diagnostic imaging services caring?

Good



Access to information

- During our previous inspection the trust reported that between 4% and 10% of records were not available at the time of a patient's appointment (October–November 2014). Between March and June 2016, this had reduced to 3% of patients who did not have their health records available for clinic.
- Staff told us they could access policies and procedures via the intranet. However access to systems could be difficult as not all staff had access to the intranet.
- Staff did not always have sufficient information about patients during clinic due to patient records not having full information available. Several staff said this meant patient records were not then updated or returned in a timely way to the records library. They would be kept by the clinician's secretary until they had the relevant information.
- Information on sexual health services, screening and contraception were on the trust website.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We saw training records that evidenced that staff had access to training in the Mental Capacity Act (2010) (MCA) and Deprivation of Liberty Safeguards (DoLS).

We rated caring as good because:

- Patients were treated with dignity and respect. Most patients were positive about the care they received.
- Staff were observed to listen and respond appropriately to patient's requests in a kind and caring manner.
- Patients and relatives told us that they found the staff to be mostly kind and helpful.

However:

- In some areas patients' privacy and confidentiality were compromised.
- Several patients gave examples where they felt they had not been informed about their treatment.

Compassionate care

- We observed care provided by nursing, medical and other clinical staff. Throughout the outpatient and diagnostic imaging departments, most staff were helpful and professional, putting patients and their relatives at ease.
- Most outpatients departments had suitable rooms for private consultations. However we observed that privacy was compromised in the reception area of the MRI waiting room as patients personal information could be overheard by other patients in the waiting room.

Outpatients and diagnostic imaging

- Patients were admitted into individual rooms so that they could discuss their procedure in privacy.
- Patients said most staff were helpful, professional, polite and kind. One relative gave an example about her relative where the consultant had “put them at ease, was empathetic and treated them with respect”. They felt the nurses also treated their relative with “great dignity”.
- We saw that clerical staff in clinics assisted patients promptly and were friendly and efficient in busy clinics.
- Between April 2015 and March 2016 the trust performed in line with the England average in the Friends and Family test. This is a single question survey asking patients whether they would recommend the department to their friends and family.
- Chaperones were available if required.

Understanding and involvement of patients and those close to them

- The design and layout of the building meant it was difficult for patients to speak with reception staff without their personal information and conversations being overheard.
- Most patients told us they had received information about their conditions and medicines.
- Several patients gave examples where they felt they had not been informed about their treatment, one said they had two operations but didn't know why they had to have the second operation.

Emotional support

- The trust was in the bottom 20% of all trusts for 28 of the 34 questions in the 2014 Cancer Patient Experience Survey. 85% of patients experience survey (2015) felt they had “understandable answers to important questions all or most of the time” which was worse than the national average of 88%.
- 79% of patients stated they were told they could bring a friend to hear the diagnosis which was the same as the national average.
- Two nursing staff told us “morning huddles” were used to identify patients with special needs so that staff could provide the appropriate care. We spoke with several other staff that did not have an awareness of the needs

of patients with complex needs and those patients who may require additional support should they display anxious or challenging behaviour during their visit to outpatients.

- We observed some departments had “dementia champions” in the clinic. In the eye clinic one member of staff told us this role meant patients with additional needs would be met when they arrived and accelerated through clinic. Staff would also ensure suitable appointments were booked and could support other clinic staff with information and advice.
- There was a Macmillan's Cancer Support centre at the hospital. It was open Monday to Friday and provided support and advice for patients, their relatives and friends who had cancer. Printed information was available (for example, on various types of cancer, how to access financial support, or how to break bad news to a relative or a friend).

Are outpatient and diagnostic imaging services responsive?

Inadequate

We rated responsive as inadequate because:

- Services were not always planned, organised or delivered in a way that met patient's needs. There were capacity issues in some clinics that meant there were insufficient numbers of clinics to deal with demand. For example, fracture clinic and ophthalmology were regularly overbooked due to demand and capacity issues meant there were delays in booking appointments.
- There were capacity issues across and number of outpatient clinics. The “access standards” meeting for July 2016 identified, 21 dermatology and three colorectal patients that would breach the two week RTT standard because of capacity issues.
- There were data quality concerns relating to the accuracy, completeness and consistency of the RTT patient tracking list. This meant RTT data provided by the trust may be incomplete and therefore inaccurate.
- Reporting turnaround times in radiology and diagnostics were not meeting best practice guidance.

However:

Outpatients and diagnostic imaging

- Waiting times for patients varied on arrival in the outpatient clinics. Improvements had been made and the trust were monitoring waiting times.
- The department was performing better than the England average with a lower proportion of patients waiting six plus weeks for diagnostic tests
- A translation service was available to enable staff to communicate with patients where English was not their first language. Written information was available in several languages and large print.

Service planning and delivery to meet the needs of local people

- Managers and staff told us there were capacity issues in some clinics that meant there were insufficient number of clinics to deal with demand. For example, fracture clinic and ophthalmology were regularly overbooked due to demand.
- Whilst there had been improvements in the number of missing notes, temporary or incomplete notes meant that that staff did not always have access to correct, contemporaneous patient records.
- We observed that waiting times varied across outpatient clinics. Most patients we spoke with were tolerant and accepted if they were not seen at their scheduled appointment times. However, some complaints had been received about delays in clinics.
- Nursing, radiology and administration staff told us that there were not enough administration staff to manage the workload. For radiology this meant radiology staff covering the administration tasks as well as treatment for patients. For example, ringing wards to arrange for patients to be brought down and contacting portage to arrange transportation. Staff and patients gave examples where patients waited longer to be seen due to staff dealing with administration problems, and delays sometimes meant inpatients missed their slots and were cancelled.
- Two week wait appointments were made via the telephone by administration staff. We observed staff in the appointment centre calling a patient to arrange. They told us four and six week wait patients received their appointment by letter. Many patients had long waits for follow up appointments.
- We saw that themes from complaints included patients complaining they had not got an appointment letter.

One patient in the eye clinic told us they had come to clinic as an emergency because the follow up appointment had not arrived. At the time we spoke with them they had been waiting over two and a half hours. They had been told by the nurse that the long wait was because there was only one doctor on that day. Another patient told us their previous appointment had been cancelled four months ago and they only had an appointment today because they had rang up and complained. Another patient had come to clinic as an emergency after seeing the GP that morning. They had been waiting for two hours and said they knew they would have to wait but they would be seen and that “staff were doing their best”.

- The trust were discussing a project with local clinical commissioning groups (CCG's) and Bart's health to develop a strategy for providing clinics nearer to people's homes. For example anticoagulant clinics.

Access and flow

- Between April and June 2015, 173 outpatient clinics had been cancelled. Between April and June 2016, 782 clinic lists were cancelled. The overall trend across all outpatients clinics showed an increasing number of clinics were being cancelled. In June 2016, 191 clinics (these included; 36 ENT, 29, rheumatology and 22, T&O clinics) had been cancelled across outpatients with most having given at least six weeks' notice, however two clinics were cancelled with less than two week's notice. The main reasons given were staff annual or study leave and other trust commitments.
- Between January and June 2016, 15% to 18% of outpatient appointments had been cancelled with many patients having had multiple cancellations. Trust figures showed that during this period between 550 and 720 patients a month had been cancelled multiple times. Across the trust there had been an overall increase in hospital cancellations.
- Booking appointments on days when doctors were on annual leave or on days when clinical audits were organised should not take place. There was a policy that required doctors to give six weeks' notice before taking annual leave, to ensure that there was sufficient time to plan appointments around doctors' availability. Doctors we spoke to were aware of this policy.
- Between January and June 2016 the trust said there had been a “significant increase” in WCUH ASI list (this is

Outpatients and diagnostic imaging

the list where patients whose appointments cannot be booked because there is no spaces available within the 18 week referral to treat (RTT) timeframe). There were booking slot issues seen in dermatology, gastrology, ophthalmology, T&O and urology. This meant patients requiring an appointment were unable to be allocated an appointment as there were no spaces available.

- Between January and June 2016 trust data showed that 100% of patients had been offered a first appointment within the target timeframe of 48 hours however staff told us that many of these would subsequently be cancelled and rearranged. This data also contradicted our findings on the inspection where we saw referrals in the appointments centre that had not been given an appointment because no slots were available.
- Some GP's referrals requested patient be given access to the 'choose and book' system where patients could make their own appointment at the time of their choice. However staff told us patients were often cancelled after they booked so they could release appointments for patients about to breach the 18 week RTT or urgent patients who needed to be seen. We followed through the process for 10 patients and observed this had happened for over 50% of patients.
- The trust's outpatient appointments centre was responsible for some of the centralised booking and management of new outpatient appointments. The central booking centre and some specialties were responsible for booking follow up appointments.
- Admissions, cancellations and referrals were managed by different teams. For example, there was a '2 week's team' and a separate '18 weeks team'. Staff working within these teams were not well supported and did not communicate routinely with each other. The trust had been recruiting to permanent posts however the service appeared disjointed and lacked oversight, which had an impact on patient flow.
- Staff took on average 20,000 telephone calls a month from internal and external callers' requiring information on new patient clinic appointments. Not all the calls from patients ringing to rebook follow-up appointments were answered. The trust reported that less than 40% of calls were answered within 60 seconds against a target of 85%.
- The trust were still in the process of building capacity in the appointment centre and training staff in the new processes. Overall there had been an improvement in performance despite an increase in the number of calls the appointment centre received.
- New referrals were recorded on the patient administration system (PAS) appointment booked, if slots available, then referral put in trays to be triaged by the consultants. Once triaged they were returned to the appointment centre and appointment changed if required. The standard operating procedure (SOP) stated consultants should aim to triage the referrals within 48 hours. We looked at 15 referrals and saw none of them had been triaged within that timeframe as they were all still waiting to be collected from the appointment centre.
- The administration lead for outpatient services produced appointment slot issue (ASI) reports weekly to identify how many patients were waiting for the first appointment. The target for referrals booked within seven days was 90%. The actual number of patients that received an appointment was 67% in May and 68% in June 2016. Four out of eight patients we spoke with complained about appointment issues, not being able to get through on the phone and discharge issues they had had.
- Some consultants told us they had no control over patient waiting lists and were reliant on the booking system to work effectively and on support from the central appointments manager and service manager. Responsibility to coordinate and arrange additional clinics was the clinic manager's responsibility. Their role was to organise space and liaise with the clinician to arrange extra clinics. Clinicians had no authority to book extra clinics to address issues with long waits.
- Staff told us the hospital's escalation process for when there were no appointment slots available did not work well because, after escalating to the service manager, they waited a long time to hear back from them and have extra clinic slots agreed.
- Escalation procedures for issues regarding availability of appointment slots contradicted the processes outlined in the SOP for urgent referrals (two weeks' wait). This meant that staff could not be clear as to which procedure they should use, and whose responsibility it was to escalate the issue to the general manager.
- The trust performance had been variable with at times being above and below the national average for the

Outpatients and diagnostic imaging

percentage of patients waiting less than 62 days from urgent GP referral to first definitive treatment for cancer waits. This meant they had been unable to meet the two week urgent referral wait performance target in every month over the 12 month collection period. The July 2016, access standards meeting, cancer dashboard reported that 11 patients were breaching the 62 day timeframe.

- The percentage of patients (all cancers) waiting less than 31 days from urgent GP to first treatment was variable with at times being better than and worse than the England average. However the hospital performed better than the national standard.
- The trust were better than the national average for the percentage of people seen by a specialist within two weeks of an urgent GP referral for cancer. However capacity issues across all outpatient clinics was a problem. The “access standards” meeting for July 2016 identified. 21 dermatology and three colorectal patients that would breach the two week standard on 13 July 2016 because of capacity issues.
- The did not attend (DNA) rates were consistently worse than England average. This meant that on average more patients did not attend their appointments. The DNA rate for June 2016 was 10.55%. This was above the trust target of 10%. This was worse than the May 2016 rate of 10% and there was an upward trend.
- The department was performing better than the England average with a lower proportion of patients waiting six plus weeks for diagnostic tests. This standard gave patients the legal right to treatment (18 week RTT) and patients should not be required to wait six weeks or longer for a diagnostic test. However reporting turnaround times were not meeting best practice guidance. For example in May 2016, 47 breast patient's reports were completed within seven days, six within 14 to 20 days, 12 within 28 to 41 days and 11 taking 42 days plus to be reported.
- In April 2016, 708 patients plain film were reported within seven days with 41 taking 14-20 days, 102 within 21-27 days, 40 within 28-41 days and 8 taking 42 days plus.
- Staff told us plain film x-rays were sent to external provider who had been contracted to report on 600 plain films a month but they were sending up to three times as many to be reported which caused delays.
- The National Diagnostic Imaging Board - September (2008) best practice guidance stated “patients have a right to expect that investigations will be seen and accurately reported within as short a time as possible.” and “imaging services should aim to provide reporting turnaround times (from examination to report being available to the referrer): Urgent cases - Immediate (within 30 minutes) Inpatients and A&E - Same working day. All other cases - By next working day. A tolerance of 90% achievement was stated as “reasonable”.
- WCUH was not meeting best practice guidance for over 25 % of patients. Several patients gave examples where they had not been told their results. For example, one patient had been sent to an external provider for a MRI. They had been impressed at the speed of the referral but the results were not sent to the GP consultant or hospital. They said they were called for an operation after a long delay with under a weeks' notice and when they spoke with the doctor it was a different diagnosis to the one that had been suggested previously. They said they had not seen their scan results and had no opportunity to discuss the results before the operation.
- The trust had suspended monthly referral to treatment (RTT) reporting from September 2014 because they had identified significant data quality concerns relating to the accuracy, completeness and consistency of the RTT patient tracking list. Since then the trust had implemented a RTT recovery programme and validation programme that was still in progress. The board performance report (June 2016) stated the trust RTT recovery plan to resolve data quality was still in the process of being developed and they had problems capturing accurate data because of IT and programming issues.
- This meant RTT data provided by the trust may be incomplete and therefore inaccurate and we could not be assured the data accurately reflected the experience of patients across all outpatient clinics.
- Managers collected information on patients waiting times which fed into the monthly outpatient (OP) services dashboard. We observed staff did not always inform patients of waiting times. We spoke with patients in the majority of outpatients clinics. Most patients when asked said they were not told of any delays and how long they may have to wait. Staff suggested that the

Outpatients and diagnostic imaging

main reasons patients had to wait were that there “not enough clinic time available, not enough staff to manage the clinics and not enough relevant consultants.

- We observed staff did not always inform patients of waiting times. Due to the design of the environment, in some clinics waiting areas were in corridors. In these instances even if staff had written waiting times in the main waiting area. Patients waiting in other areas would not be aware unless a staff member verbally told them. We observed one nurse verbally informing patients of the delay.
- We spoke with patients in the majority of outpatient's clinics. Three patients when asked said they were not always told of any delays and how long they may have to wait. One patient that regularly attended outpatient's said they sometimes saw the whiteboards being updated and sometimes the nurse verbally told patients but it depended on the nurse. Two others told us they had never been told how long they had to wait.
- The trauma and orthopaedics clinic regularly overrun by approximately one to two hours. Staff told us no actions had been taken by the management to ensure that appointments were managed more effectively to prevent delays.

Meeting people's individual needs

- During our inspection we observed many patients asking staff how to find their way. All the staff we observed being asked responded in a patient and helpful way. Patients told us that the current signage and directions for moving around the hospital were poor and it was difficult to find your way around. The “Whipps Cross Hospital Capital Programme incorporating Estates Backlog Maintenance Plan (2016/17)” highlighted the hospital was “in poor condition” with inconsistent and out-of-date signage that was not compliant with HBN standard for Dementia-friendly health and social care environments (health building notes give best practice guidance on the design and planning of new healthcare buildings and on the adaptation/extension of existing facilities HBN 08-02)). They planned to complete a survey and replace signs as necessary with the intention of applying “a common consistent HBN compliant style and system. However, whilst the trust had recognised this as a necessity budget constraints meant it had not been included as a priority at this time.
- The patient led assessment of the care environment (PLACE) assessment identified areas within outpatients that did not meet the recommendations for patients with dementia. For example, the lighting, or natural light from windows, made floors appear to be wet or slippery. Not all doors had clear signage, no toilet door signs used both pictures and text and toilet seats, flush handles and rails were not in a colour that contrasted with the toilet/bathroom walls and floor. General comments from patients included, “some waiting areas are too small such as blood clinic therefore crowded”.
- The May 2016 PLACE assessment also identified that current seating across all clinics did not provide for the range of patient needs including having enough chairs of different heights, chairs with and without arms and bariatric chairs.
- During our previous inspection in December 2014 we had found insufficient seating in most of the outpatient clinics. This meant patients often had to move to other clinic waiting areas to find a seat or wait in corridors. We had observed that patients for the sexual health clinic were required to sit in the main corridor underneath the sign ‘sexual health clinic’, which potentially compromised their privacy. During this inspection we observed a similar situation. Staff told us there was very little they could do due to the design of the building and volume of patients attending clinics. Seating was a major problem in many clinics but particularly very busy clinics like orthopaedics (fracture and trauma clinics) and phlebotomy. The trust had provided seating in corridors between clinics to try and alleviate the problem however this meant that corridors were narrower making it more difficult to use for wheelchair user's or those using a walking aid. In the main eye clinic reception we saw patients in wheelchairs waiting in the main corridor which was the main fire exit.
- There was drinking water available in some waiting areas. We observed there were jugs of water and plastic cups on trays in some clinics.
- There was written information available for patients. Some of these leaflets had been produced by the trust and other items had been provided by external agencies such as the Royal College of Ophthalmologists.

Outpatients and diagnostic imaging

- A translation service was available to enable staff to communicate with patients where English was not their first language. We saw written information was available in several languages and large print.
- The outpatients and diagnostics services in the main building were accessible as people could access on foot or use the lift.
- Staff used a “forget me not” process for identifying patients that had additional needs, for example, Dementia. Records were marked with a flower to identify that the patient needed additional support. This meant support could be provided when it was needed.

Learning from complaints and concerns

- The April 2016 trust board performance report showed there had been a decrease in managing complaints within the 25 day target from 57% in March 2016 to 48% in April 2016. The trust were monitoring performance but did not have a targeted action plan in place to identify when they expected to meet their target of 80%.
- Complaints were triaged by the central complaints team, who contacted complainants by telephone wherever possible, negotiated the timeframe for response and developed a complaints management plan to follow when investigating a complaint.
- Complaints were handled in line with the trust policy. The outpatient manager dealt with initial complaints that had not been able to be resolved by individual managers in each clinic department. If they were unable to deal with a patient's concerns satisfactorily they would be directed to the patient advice and liaison service (PALS).
- In most of the areas we visited information on how to make a complaint was displayed. There were some leaflets available in outpatients departments including comment cards, which patients could complete and post. Staff confirmed that they were made aware of complaints if it was relevant or involved them and received feedback individually and via staff meetings and team “huddles”.
- There was no mandatory complaints training provided to staff, but it was provided on an ad hoc basis. The principles of good complaints handling were included in

the policy. Where PALS received complaints that required investigation by managers there was an electronic system to delegate responsibilities and track progress of the complaint.

- Managers told us that feedback on any trends or themes about complaints would be provided if it was relevant to each department.

Are outpatient and diagnostic imaging services well-led?

Inadequate



We rated well-led as inadequate because:

- There was no consistent strategy across the outpatients' clinics and specialities. Some specialities were working in silos with their own processes and booking systems and no one person had an overview of what needed to be done to join everything up.
- The governance arrangements were not effective. Risks were not always identified and when identified not always managed appropriately, effectively or in a timely manner. For example, policies and processes were not always adhered to and staff felt financial pressures impacted on the trust's ability to meet patient's needs.
- The trust had put in place internal processes and systems to collect RTT figures for all outpatient clinics however, we were not assured these were robust or effective enough to capture all the information from the various sources they needed to have a full picture of performance across all outpatients departments. As such, they were unable to deal with the impact on patients adequately.
- We received written and verbal concerns about the culture at WCUH. Several staff raised concerns about bullying and harassment and management and local CAG not effective in managing the issues.
- Staff told us it was difficult to get concerns discussed and actions taken when they highlighted issues that impacted on patients and staff. Some leaders were out of touch with what was happening on the front line and there was a lack of clarity about who had authority to make decisions and how individuals were held to account.

However:

Outpatients and diagnostic imaging

- Improvements had been made in ensuring temporary patients records were available for clinics. Twice daily record audits were undertaken to monitor the availability of records.
- Most staff said they liked working for the trust but could give examples where they felt improvements were needed. Several staff told us the hospital was “like a family” and most staff knew each other and worked well together.

Leadership of service

- Radiology and diagnostics were led by the head of imaging, clinical director and site clinical consultant lead. Outpatients were led by the general manager. They reported to the head of outpatients who reported to the director of operations for clinical support services (CSS) and clinical academic group (CAG).
- Some staff felt the executive management team were visible, and others felt they were not. Several staff said they thought the board were “biased towards the Royal London staff. This meant WCUH did not get the equipment or resources they needed.
- Most staff said they did not see senior managers very often. Managers told us that the structure of outpatients CAG meant senior managers often had responsibility for other services as well as outpatients across other hospitals in the trust. This limited the time they had available to be visible for staff.
- Some managers and clinicians were concerned about the time it took to get concerns discussed and actions taken when they highlighted issues that impacted on patients and staff. For example; in outpatients most staff did not know who had overall responsibility for monitoring waiting lists across outpatients and ensuring patients were seen within the 18 week RTT. Several staff told us management and the local CAG were not effective in managing issues and this meant “nothing ever got sorted as too many people were involved in making decisions”.
- Not all specialties used the central booking system. Some specialties had their own systems and booking practices. This meant that leaders were out of touch with what was happening on the front line. There was a lack of clarity about authority to make decisions and how individuals were held to account.
- Staff in outpatient clinic were very busy and the management and meetings structure and design of the environment meant that opportunities to work together to resolve conflicts were limited.
- Two managers told us they used daily “senior huddles” to cascade information, including information on incidents and that managers were then responsible for sharing information to their teams. Several nursing and administration staff we spoke with said they did not get to hear about feedback from incidents from their managers. This meant it was difficult to identify where individual staff members shared discussion and opportunities to share the responsibility to deliver good quality care took place. Radiology staff said they had good local leadership and they felt well supported.
- Staff were not clear about the trust’s lone working policies. For example; one manager said they did not know there was a lone working policy and they did not need to know about it as staff were never alone as there were always other staff around. This meant we were not assured managers and staff knew about or adhered to the trusts lone working policies.
- This was important as radiology and diagnostics staff and nursing and administration staff could be working alone at weekends or overnight.
- The trust had been in the process of reorganising the outpatient services management structure and core line management responsibilities. This had started in July 2015. This meant many staff had different line management, and a change in their role and responsibilities. This was still in progress so was not yet embedded in the teams. The trust told us that once established the new structure would ensure there was a clear accountability line and management structure.

Vision and strategy for this service

- Outpatient managers told us of recent changes and recruitment that was taking place to develop the service. This included environmental changes and changes to staff structures.
- Most staff knew about the trust’s values. Two staff explained what that meant for them in their role.
- Work towards re-organisation and structure of outpatients had begun. However there did not appear to be a robust trust level strategy to bring clinicians

Outpatients and diagnostic imaging

across all the specialities for the outpatients' service together to improve performance. Many staff told us that the current CAG structure was unworkable and too large.

- Reporting structures were clear however accountability for decision making was unclear. This meant getting a cohesive strategy and plan in place with a clear strategy for the whole service had not yet been achieved.

Governance, risk management and quality measurement

- At the previous inspection we had highlighted that the trust aspired to have 98% of medical records available at clinics. Previously they had not been meeting this target and patients had told us their records were not available at their appointment. During this inspection we found improvements had been made and twice daily record audits were undertaken to monitor the availability of records. These detailed how many records were required and how many temporary files were made-up.
- Staff in the records library made up temporary records with information they had available on the patient electronic record for clinics. This was printed and put into the temporary files before delivering to clinics. This process had ensured all patients had notes available when they attended clinic; however there was no action plan in place to determine where missing records were.
- Staff we spoke with said they knew secretaries kept patient records if they needed to add information to them but did not know who had what. There was no staff capacity to deal with this issue at the present time as the focus was on ensuring patients had notes available for clinics. Systems were not effective in ensuring all patient's notes were tracked and lack of knowledge about where patient's permanent paper records were was not on the risk register.
- The trust had made progress in ensuring all patients had notes available however all the information in the file might not be up to date. One patient told us they had not been able to be seen as their temporary file had not included recent letters from other consultants and they had been cancelled. Staff gave us other example of similar situations. Records library staff were only able to print off patient information if it had been put on the system. If there were delays in other departments or delays in reporting, for example scans or x-rays, then current information was not available. This meant that risks about incomplete records were known but were not always being effectively managed. The trust had made improvements to ensure the majority of patients had a temporary record but all current information might not be available due to delays elsewhere in the patient's pathway.
- Risks identified by staff and known to the trust were not all on the risk register and there was a difference in what staff raised as concerns and what were recorded as risks. For example: staff in outpatients raised concerns about staff and patient safety due to physical and verbal aggression between patient and patients and staff. We saw written details of three incidents involving patients and staff, one where police were called. Staff were concerned for their own safety and said despite highlighting concerns no additional training, resources or Individual plans or risk assessments had been put in place to ensure staff were adequately trained and know what to do in similar situations. One member of staff said they "did not know whether then should run or try and restrain the person". The managing abuse and violence policy (2014) gives a clear framework for managers to follow when risks are identified. Departmental risk assessments had not been undertaken to look at what could be done to manage risks and discussion had not taken place with staff to check they knew what they should do in a similar situation. This meant that policies and procedures were not always implemented or adhered to.
- The trust had suspended collection of referral to treat data in 2014 due to data collection being unreliable. Since then they had put in place internal processes and systems to collect RTT figures for all outpatient clinics. We were not assured these were robust or effective enough to capture all the information from the various sources they needed to have a full picture of performance across all of outpatients departments.
- Due to the trust not being able to meet all its RTT timeframes patients were regularly being sent outside of the hospital to other providers ("outsourcing") to try and manage the delays. However they did not have robust tracking system in place to monitor how many patients were being outsourced and what the outcome had been. The weekly "access standards" meeting

Outpatients and diagnostic imaging

highlighted systems were not robust enough to track patients and changes were in the process of being made to ensure all patients would be tracked. This risk was not on the risk register.

- The department was also “outsourcing” clinic typing (patient letters) due to backlogs. For example, in July 2016 the turnaround time for T&O was recorded as eight days with 670 patient letters outsourced externally. The ENT turnaround time was five days with 1000 plus letters being outsourced. It was unclear what processes were in place to ensure patient outcome letters were recorded on patient files.
- Imaging monthly performance reviews (IMP) reviews identified the risk of breakdowns with the MRI scanner that could lead to increased levels of stay and cancellation of patients leading to increased financial costs. Between July 2015 and July 2016 the MRI scanner was recorded as breaking down 18 times. The majority of occasions the scanner was out of use for was a minimum of 30 mins to a maximum of four days over the 18 recorded occasions. None of these occasions were reported as an incident and recorded on a datix.
- On the risk register other key pieces of equipment were identified as needing replacement in the financial year 2015/16, it was recorded that due to financial constraints this would be delayed until at least the financial year 2016/17. The report highlighting an “inherited risk register” that had not been fit for purpose and required extensive review. The trust planned to establish a working group of corporate and site risk leads to assess risk management capacity, capability and training needs however this was not yet in place.
- Governance procedures to monitor waiting lists, waiting times, frequency of cancelled clinics, and RTT timelines for patients were not robust enough which meant the impact on patients was not fully known. The trust were aware RTT performance information they were gathering was likely to be inaccurate. They had put in place systems to capture information but it relied on the systems being fit for purpose and able to capture full data.
- The Audit and Risk Committee had set out an outline strategy for the identification of data quality issues across the trust along with a framework and process for driving improvement. They planned to develop a detailed strategy complete with implementation plan and milestones. This would be presented to the Audit and Risk Committee at its October 2016 meeting. In the meantime staff told us they were reacting to possible breaches of RTT timelines by trying to resolve each situation in the best way possible. Usually this meant putting on additional clinics or cancelling booked patients to fit those about to breach.
- Decisions to put on additional clinics to manage the waiting list were dependent on clinicians having the time available for additional clinics and clinic space and nursing capacity available to run clinics. This process was not joined up. For example, clinicians had to find out if clinic rooms were available by talking to various people in outpatients. There was no one person with an overview of room’s available and nursing capacity who had overall responsibility to organise. This meant various discussions needed to take place with different people to pull together the additional room and staff resource to put on a clinic and this all took time to organise.
- There were structures in place to maintain clinical governance and risk management. For example, a monthly outpatient services dashboard and CSS detailed performance information tracking. This tracked various performance systems including statutory and mandatory training, appraisal rates, complaints and response times, medical records performance with twice daily audits and quality and safety meetings.
- Staff in diagnostic imaging had monthly imaging clinical governance meetings in which they discussed learning from incidents and complaints, policies, clinical issues and trust information. We saw minutes that confirmed this.

Culture within the service

- The trust had policies in place to ensure people were not discriminated against. Staff we spoke with were aware of these and gave us examples of how they followed this guidance when delivering care and treatment for patients. However some staff thought they were discriminated against because of their culture or ethnicity.
- At the previous inspection staff had approached us because they felt that they were intimidated or bullied by the managers and felt that they had exhausted all avenues available to them in order to resolve the issue. During this inspection we were again approached by staff that raised similar issues. Concerns were raised about human resource (HR) processes that were not felt

Outpatients and diagnostic imaging

to be independent or followed proper procedures. During the previous inspection the director of human resources had reassured us that they had invested in training and various programmes to address these issues.

- During this inspection we received written and verbal concerns about the culture at the trust. Several staff raised concerns about bullying and harassment. One told us they had reported their concern to a senior manager but did not feel they had been listened too and the situation had not been resolved instead they felt they had been punished for reporting it. One manager told us that the “previous culture of grievance and counter grievance was still prevalent and got in the way of performance management” but they had more support from HR department. Another member of staff told us they had raised concerns but did not feel they could go above their line manager and their concern had not been taken seriously and the situation had not been resolved. It was unclear whether the trust had developed a robust action to address these issues and staff we spoke with were not aware that any plan was in place.
- We observed that most outpatients staff were patient focused and wanted to provide a better service for their patients. Staff we spoke with said they aimed to provide a good experience for patients who visited their department but often felt limited by the time they had to spend with patients as many clinics were very busy.
- Staff told us they were aware of the trust’s whistleblowing and safeguarding policy and they felt able to report incidents and raise concerns through these processes.

Public engagement

- The trust told us they used volunteers to provide support to patients in outpatients. This included manning information points throughout outpatients. We observed volunteers directing patients to various departments.
- Patient Advice and Liaison Service (PALS) information was available on notice boards in waiting areas. These informed patients of the PALS service and invited patients to provide feedback and comments.
- The trust gained patients views about services in a number of ways. The June 2016 board report highlighted that the percentage of patients responding

positively to the friends and family test question, “would recommend the trust to friends and family as a place to receive care”, was above the 80% target for all outpatients on all sites. The trust did not separate its responses into specialities or individual hospitals so we were unable to determine how many responses were specifically about individual outpatient services at WCUH.

- The friends and family test response rates across all the trust sites were below their target response rate of 30% achieving between 11 and 19% between August 2015 and April 2016.

Staff engagement

- Overall the trust were worse than the national average (combined trusts) in 26 of the 32 key findings in the 2015 NHS Staff Survey. For example: 47% of staff recommended the trust as a place to work which was worse than the England average of 58%. 56% of staff would be happy if a friend or relative needed treatment with the standard of care provided by the trust which was worse than the England average of 67%. 37% of staff experienced harassment, bullying or abuse from staff in last 12 months which was worse than the England average of 24%. 21% of staff felt they had experienced discrimination at work in last 12 months which was worse than the England average of 10%.
- The survey highlighted small improvements since the 2014 staff survey, for example in staff motivation at work and effective use of patient / service user feedback. However when compared with other combined acute and community trusts in England the overall scores were worse than average.
- The trust was rated as ‘worse than expected’ for Induction and Feedback in the 2015 General medical council (GMC) training survey.
- The trust’s sickness absence rate had been better than the England average since February 2015.
- Throughout the inspection, most staff were welcoming and willing to speak with us. Some staff said they could see improvements were taking place and the trust were better at keeping them informed of changes that were happening that affected them.
- The trust had many staff that had worked at the hospital for many years. Staff said they liked working for the trust but could give examples where they felt improvements were needed. Several staff said they did not feel listened

Outpatients and diagnostic imaging

to when they suggested changes that could easily be made to improve patients and staff experience. Three staff told us the hospital was "like a family" and most staff got on with each other and knew each other.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital **MUST** take to improve

- The trust must improve bed management, theatre management and discharge arrangements to facilitate a more effective flow of patients across the hospital and to improve theatre cancellation and delayed discharge rates. This should include improving flow of patients into and out of critical care.
- The trust must improve compliance and awareness of trust infection prevention and control policies and processes to ensure surgical staff do not wear theatre scrubs and clogs outside the operating theatres. Additional, the trust should review its infection control policies for ensuring infectious patients are effectively and safely managed in ward areas.
- The trust must improve compliance with venous thromboembolism (VTE) assessments.
- The trust must work towards improving the organisational culture to reduce instances of unprofessional behaviours and bullying and ensure all staff feel sufficiently supported by their managers.
- The trust must ensure all patients are treated in a caring and compassionate manner, and ensure their privacy and dignity is maintained.
- The trust must ensure that patients' pain levels are monitored and acted on appropriately and that pain relief is provided to patients when required.
- The trust must ensure there are sufficient numbers of qualified, skilled and experienced staff employed and deployed to meet the needs of patients. This should include ensuring staff have the right skills to recognise and manage the deteriorating patient.
- The trust must ensure all staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- The trust must ensure governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services. This should capture relevant elements of

good governance including an adopting a positive incident reporting culture where learning from incidents is shared with staff and embedded to improve safe care and treatment of patients.

- The trust must ensure staff on the wards receive sufficient handover including patients' infectious status.
- The trust must ensure all patients are screened for malnutrition as required by NICE guidelines.
- The trust must ensure that patients needing urgent referrals or follow up appointments for assessment or treatment are followed up promptly.

Action the hospital **SHOULD** take to improve

In addition the trust should:

- The trust should improve its performance against the national four hour target for treatment and admission/discharge in ED.
- The trust should ensure staff always have access to reliable equipment to minimise potential delay to treatment.
- The trust should ensure mixed-sex accommodation breaches are reported without any delays and as required by NHS England guidance.
- The trust should consider the use of an acuity tool to manage capacity on delivery suite.
- The trust should improve access to chaplaincy service to meet people's spiritual and emotional needs.
- The trust should ensure the needs and preferences of patients and their relatives are central to the planning and delivery of care at the hospital.
- The trust should ensure the physical environment is fit for purpose,
- The trust should ensure children with learning disabilities are identified on presentation to the hospital and facilities to support these children improved.
- The trust should ensure patients are fully involved in decisions about their care and treatment.
- The trust should ensure that records are complete, accurate and do not contain variances and discrepancies.

Outstanding practice and areas for improvement

- The trust should improve the availability of medical records and reduce the requirement for the need for temporary notes.
- The trust should implement a systematic approach to the assessment of individual risks to the health, safety and welfare of patients.
- The trust should review medical staffing at night in medical services and nurse staffing on acute assessment unit.
- The trust should ensure care plans reflect the individual needs of patients, with particular focus on those with complex needs.
- The trust should ensure compliance with the Mental Capacity Act (2005) and Deprivation of Liberty safeguards (DoLS).
- The trust should ensure more patients are clinically assessed within the 15 minute national target.
- The trust should ensure nursing staff caring for patients requiring tracheostomy care are sufficiently trained.
- The trust should ensure all staff that provide care and treatment to children have the appropriate training.
- The trust should ensure the emergency theatre is compliant with the surgical safety checklist process.
- The trust should ensure there are effective systems in place to ensure patient records are tracked and available when required.
- The trust should ensure that timely arrangements are in place to replace ageing diagnostic imaging equipment identified as at risk of failure.

Requirement notices

Action we have told the provider to take

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

Regulated activity

Surgical procedures

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

A lack of available patient transport led to out of hours discharges. Patients frequently waited for their medication and blood test results which also caused frequent delays in discharges. Some theatre cancellations happened on the day of surgery due to overrunning of surgical lists.

This was a breach of regulation 9(1): The care and treatment of service users must – (a) be appropriate, (b) meet their needs and (c) reflect their preferences.

Providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.

Not all patients were screened for malnutrition.

This was a breach of regulation 9(3)(i) where meeting a service user's nutritional and hydration needs, having regard to the service user's well being.

Regulated activity

Surgical procedures

Regulation

Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Staff did not always comply with the trust's infection prevention and control policy. Surgical staff wore theatre scrubs and clogs unchallenged across different areas of the hospital and patients' infectious status was not

Requirement notices

always handed over to staff from other wards/units. The trust's incident reporting process was inconsistently applied by staff and there was limited involvement of the infection prevention and control team.

Surgical wards were not compliant with the trust's target for the completion of venous thromboembolism (VTE) assessments. Surgical site infection data was not effectively captured and the risks to health and safety were not captured or escalated effectively.

Regulation 12(1) states that care and treatment must be provided in a safe way for service users. Service providers must comply by (a) assessing the risks to the health and safety of service users of receiving the care or treatment; (b) doing all that is reasonably practicable to mitigate any such risks.

This was a breach of regulation 12(2)(h) assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are health care associated.

Regulated activity

Surgical procedures

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

There were insufficient surgical staff cover at night to safely care for patients at all times. The use of agency staff was high and the quality of the agency staff compromised patients' care and treatment. Not all staff complied with mandatory and statutory training.

This was a breach of regulation 18(1): Sufficient numbers of suitably qualified, competent, skilled and experienced persons must be deployed in order to meet the requirements of this Part. Providers must deploy sufficient numbers of suitably qualified, competent, skilled and experienced staff to make sure that they can meet people's care and treatment needs.

Regulated activity

Regulation

Requirement notices

Surgical procedures

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided. The hospital did not effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others.

The hospital did not evaluate and improve their practice in response to feedback provided by staff. A number of nursing staff in different surgical areas told us about ongoing issues of bullying and harassment. We observed poor collaboration and communication between staff, and staff told us about difficult and negative working relationships.

The hospital did not effectively assess, monitor and improve the quality of the service. Theatre utilisation was low due to late starts, delays between cases and early finishes. Local clinical and quality audits were not regularly carried out. Clinical governance meetings (apart from theatres) were not well embedded, poorly attended and some were not represented by service leads. Surgical and cancer clinical academic group (CAG) meetings did not appear to feed into the specific surgical speciality clinical governance or ward meetings.

Significant data quality concerns led to suspension of the monthly 18-weeks referral to treatment Time (RTT) reporting.

This was a breach of regulations 17(2)(a) and 17(2)(b) which require the service provider to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.

This section is primarily information for the provider

Requirement notices

Nursing care

Treatment of disease, disorder or injury

Regulation 10 HSCA (RA) Regulations 2014 Dignity and respect

End of life patients' privacy, dignity and confidentiality was not always respected. We did not observe consistent compassionate care.

This was a breach of regulation 10(1): Service users must be treated with dignity and respect and 10(2)(a) ensuring the privacy of the service user. When people receive care and treatment, all staff must treat them with dignity and respect at all times. This includes staff treating them in a caring and compassionate way.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 9 HSCA (RA) Regulations 2014 Person-centred care

We observed some end of life patients appeared visibly in pain, but staff did not respond to this by providing them with adequate analgesia.

This was a breach of regulation 9(1): The care and treatment of service users must – (a) be appropriate, (b) meet their needs and (c) reflect their preferences. Providers must do everything reasonably practicable to make sure that people who use the service receive person-centred care and treatment that is appropriate, meets their needs and reflects their personal preferences, whatever they might be.

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Systems and processes were not established or operated effectively to ensure the provider was able to assess, monitor and improve the quality and safety of the services provided. The hospital did not effectively assess, monitor and mitigate risks relating to the health, safety and welfare of service users and others.

Requirement notices

The hospital's governance arrangements were not effective. Risks were not always identified and when identified not always managed appropriately, effectively or in a timely manner.

There were capacity issues in some clinics that meant there were insufficient numbers of clinics to deal with demand and this affected patients' waiting times. There were data quality concerns relating to the accuracy, completeness and consistency of patient tracking list. The quality of the referral to treatment data was poor and the hospital suspended reporting in September 2014.

The hospital did not evaluate and improve their practice in response to feedback provided by staff. Staff told us they were not able to discuss concerns and actions were not taken when they highlighted issues that impacted on patients and staff. Several staff raised concerns about bullying and harassment and poor overall management.

This was a breach of regulations 17(2)(a) and 17(2)(b) which require the service provider to assess, monitor and improve the quality and safety of the services provided in the carrying on of the regulated activity (including the quality of the experience of service users in receiving those services) and to assess, monitor and mitigate the risks relating to the health, safety and welfare of service users and others who may be at risk which arise from the carrying on of the regulated activity.