Whittington Health NHS Trust

Evidence appendix

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This evidence appendix provides the supporting evidence that enabled us to come to our judgements of the quality of service provided by this trust. It is based on a combination of information provided to us by the trust, nationally available data, what we found when we inspected, and information given to us from patients, the public and other organisations. For a summary of our inspection findings, see the inspection report for this trust.

Facts and data about this trust

Whittington Health NHS Trust is an integrated care organisation, providing both acute, community and child and adolescent mental health services. The trust has one acute hospital site, shown in the table below.

Name of acute hospital site	Address	Details of any specialist services provided	Geographical area served
Whittington Hospital	Magdala Avenue, London, N19 5NF	Accident and emergency department, ambulatory care unit (adults and children), cardiology, child and adolescent mental health services, community services dermatology, diagnostics, maternity, nephrology, plastic surgery, trauma and orthopaedics	Islington and Haringey as well as other London boroughs including Barnet, Enfield, Camden and Hackney

(Source: Routine Provider Information Request (RPIR) – Sites tab)

Whittington Health NHS Trust ("the trust") is an integrated care trust with over 352 inpatient beds, providing over 40 acute and 60 community services. The trust serves more than 500,000 people living in Islington and Haringey, and as well as those living in Hackney, Camden, Barnet and

Enfield. Its services are materially commissioned by the collectively financially challenged North Central London commissioners.

In 2018/19, the trust saw 18,256 emergency admissions, up 4.6% on previous year; 325,129 community nursing visits, up 7.6% on previous year; 2,224 elective inpatient admissions, and 21,292 day-case admissions, up 8% on previous year.

Is this organisation well-led?

Leadership

There were no Black and Minority Ethnic (BME) executive board members. Six of the executive board members were female (75%).

Of the non-executive board members three (50%) were BME and four (67%) were female.

Staff group	BME %	Female %
Executive directors	0%	75%
Non-executive directors	50%	67%
All board members	21%	71%

(Source: Routine Provider Information Request (RPIR) – Board Diversity tab)

There was a programme of board visits to services which included hospital and community locations. Each non-executive director was scheduled to visit one site per month. However, staff reported variable visibility of the non-executive directors. Staff said that most executive directors were very visible and approachable.

The trust board had the appropriate range of skills, knowledge and experience to perform its role effectively. We spoke with all eight of the executive directors and four of the non-executive directors including the trust interim chair. We found that, as a whole, the trust board members had a variety of backgrounds and experiences from the political, private and public sectors. At the time of the inspection the new substantive chair had been appointed and was to join the trust in April 2020.

The leadership of the trust's finance function has undergone significant change over the past 12 months period as follows:

- There has been two Interim Board Chairs since July 2019.
- The current Audit Chair has been in post since July 2019.
- The trust has an Acting Chief Finance Officer since September 2019 and Interim Deputy Director of Finance.

Despite this change backdrop, interviews conducted during the Well-Led review showed a generally high level of support, satisfaction and confidence in both the trust finance function and the acting chief financial officer. This confidence is supported by evidence in that the finance team had successfully stewarded the trust in delivering its financial operating plans since 2015/16.

In addition to the interim chair and CEO, the board had four non-executive directors and eight executive directors. The chief executive officer (CEO) Siobhan Harrington was appointed in September 2017. There was a range of skills among the non-executive directors, who had joined the board on a variety of dates from 2014 to 2018. We talked with most of the trust's directors at length during the inspection about their specific areas of responsibility and more generally. We found that as a group, the board had extensive private and public sector experience. However, some staff reported that there was imbalance of experience amongst non-executive directors with more skills in finance rather than clinical experience.

Succession planning needed development throughout the trust. The new appointment of a permanent chair following a significant gap should be used by the trust to establish a clear strategic plan for future NED appointments that will provide a more rounded and strategic board.

There was a regular cycle of board development days with NEDs committing up to two and a half days each month to trust business. The trust had introduced a range of leadership development activities and training to develop staff at all levels. This covered topics such as leadership, appraisal training, absence and change management. This was still a new initiative and many junior staff had at the time of our inspection had little leadership training.

The executive team comprised: chief nurse and director of allied health professionals (in post since February 2018), chief operating officer (in post since March 2016), medical director (in post since June 2019), chief finance officer (in post since September 2019) and three non-voting members of the board: medical director integrated care (in post since May 2018), the director of workforce (in post since June 2015) and the director of strategy, development and corporate affairs (in post since May 2018). It is unusual for a trust to have two medical directors; however, we found that the additional medical director for integrated care added a valuable capability for this integrated trust.

We observed, and saw from the board meeting minutes, variable challenge and scrutiny from non-executive directors. However, we saw that the chair promoted contributions from all members and the agenda balanced time effectively between quality, finance/performance and strategy.

The trust leadership team had a comprehensive knowledge of current priorities and challenges across all sectors and took action to address them. All the board members had a good knowledge of the key issues within the trust, even when they were outside of their direct portfolios. It was clear that the board was acting as a whole with an ongoing comprehensive discussion continually taking place.

In April 2019 the trust commissioned work around board development to improve the effectiveness of the trust board and to increase the knowledge and skills they need to lead and embed quality improvement. At the time of the inspection, the trust was in the process of implementing the trust board development programme which was a series of seven workshops related to different topics such as: the board's role in overseeing culture, board impact and effectiveness of system leadership and the NHS board of the future amongst others.

The trust had an operational structure comprising five integrated care service units (ICSU), each led by a clinical director, head of nursing and director of operations. The five ICSUs within the trust were: children and young people services, acute patient access, clinical support services, women's health, emergency and integrated medicine, surgery and cancer, adult community health services.

The trust board and senior leadership team displayed integrity on an ongoing basis. We found all the members of the board we spoke with to be open and honest. They never took a defensive approach to issues we raised with them and were willing to acknowledge areas for improvement in a positive and constructive manner.

We found the quality of leadership at ICSU level to be generally good. However, below that level there were pockets of poor leadership where the trusts needs to identify leaders who need additional support and development. Not all leaders in the organisation followed the good leadership exhibited by the board. Divisional management arrangements had been strengthened, but more work was required to ensure these were embedded and are able to evidence that they are having a positive impact on delivering financial performance and cost efficiencies. For example, Emergency and Integrated Medicine was struggling to constrain expenditure within budgets and had not delivered its efficiency programme as per the current year to date performance. The trust had a good service line reporting system which was used across the divisions, but effective use of outputs to challenge and improve performance was variable.

Our review of board files indicated that Fit and Proper Person checks were in place. The trust had a fit and proper persons policy which covered arrangements for both recruitment and ongoing assurance. This was in line with the Fit and Proper Persons Requirement (FPPR) (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014; Regulation 5). This regulation ensures that directors of NHS providers are fit and proper to carry out this important role. The regulation came into force in November 2014. As previously, the trust policy did not have a version number or review date recorded, however it did state the date it was last updated. As part of our 'Fit and Proper Person' review, we looked at five personnel files and checked that all of the relevant checks and paperwork had been completed. Our review showed that all the files had relevant checks in place as required by the policy.

Medicines issues are discussed at the DTC or at the Medicines Safety Group (MSG). Chief Pharmacist is line managed by the director of operations for the acute access, clinical support services and women's health business unit and has a professional reporting line to the medical director. This ensured that pharmacy issues are communicated regularly to the senior leadership team via the trust board.

Vision and strategy

The trust had a clear vision and set of values and four key objectives as the top priorities. We found the vision to be simple, consistent and having continuity throughout our conversations with staff at all levels. The trust's vision was 'helping local people live longer healthier lives'. There was also a consistent strapline used by the trust of 'Better Never Stops'. Since our last inspection we found that the trust was much more aligned to this vision and the previous separation of hospital and community activity had been greatly reduced. In particular most of the community staff we spoke with felt they were now full and equal members of the trust.

The trust stated, 'What we do' as: "Lead the way in the provision of excellent integrated community and hospital services".

The trust's core values were Innovation, Compassionate, Accountable, Respectful and Excellent (ICARE).

Most staff we spoke with were aware of the trust's vision and values. We were impressed by the clarity among all staff, from the board to the front line; the trust was there to deliver good outcomes for their local community. Staff, patients, carers and external partners generally had the

opportunity to contribute to discussions about the strategy, especially where there were plans to change services. The trust was rooted in and connected to its community in its day to day work. The trust embedded its vision, values and strategy in corporate information received by staff.

The trust had planned services to take into account the needs of the local population. For example, the emergency response 'Hospital at Home' team. An initiative which works with health and social care partners to try and prevent patients having to be admitted to the hospital.

The trust had four key objectives that underpinned its vision:

- Delivering outstanding safe, companionate care.
- Empower, support and develop engaged staff.
- Integrate care with partners and promote health and well being.
- Transform and deliver innovative financially sustainable services.

There was a robust and realistic strategy for delivering priorities and improving patient care. As an integrated trust for a number of years, the vision, strategy and approach was an excellent example of how integrated care can work for the benefit of patients. Local providers and people who use services had been involved in developing the strategy.

The trust was involved with the local North Central London Sustainability and Transformation Plan (STP). The trusts medical director sits on the STP programme delivery board and also co-chairs the health and care cabinet, which sets the clinical strategy. Other board members were involved in key STP meetings.

Following our last inspection, we noted that the trust had not dealt with three keys issues:

- The poor staff culture and allegations of bullying.
- The under capacity of the critical care unit.
- The leadership arrangements within the Children and Young people ICSU.

During this inspection we found that all these issues had been fully addressed by the trust and had led to service redesign where necessary.

- The trust has identified a number of areas where it can make improvements in the future;
- Developing its role as the leader of a sector integrated care system.
- Further integrating care in localities with borough partnerships and primary care networks.
- Developing its medium-term financial strategy, redesigning support services and more efficiently managing bank rates for staff across the STP area.
- Transforming services such as, outpatients, digital and orthopaedic.
- Improving the estates strategy.

During our inspection we found that the estates strategy was not comprehensive and was behind the clinical strategy. There was no vision for what the estates would like in the long or in some area the medium term.

The trust had a Medicines Optimisation Strategy and business plan in place which was commissioned by the trust Board. The trust took part in the Carter review and prioritised the

Hospital Pharmacy Transformation Plan (HPTP) into their strategy. The trust works closely with the regional STP and they are represented on the NCL Joint Formulary Committee and NCL Medicines Optimisation Committee.

The key priorities of the trust regarding medicines optimisation were outlined in the Medicines Optimisation Strategy and business plan. Staff knew about the medicines optimisation strategy as it was shared in various team meetings and in 1:1 discussions (for example, during appraisals). Elements of the Carter review action plan were evident, such as the need to improve procurement and increase the number of non-medical prescribers across the trust in the future. The trust used NHS benchmarking and Model Hospital data to identify new themes to enhance medicines safety.

Culture

The trust's strategy, vision and values underpinned a culture which was patient-centred. There had been significant improvements in culture since our last inspection. Most staff we spoke with during our core service inspections and within focus groups held before the Well Led inspection, said that they felt supported respected and valued. Staff felt able to raise concerns without fear of retribution. However, a small number of staff felt that the trust still had more work to do on addressing long running concerns of harassment and bullying.

The trust had shown an openness and desire to address the concerns raised by some staff around bullying in a proactive and engaging way. The trust commissioned an independent review of this issue which was then shared with staff and publicly. The trust then used this report as a platform for engaging staff and making improvements.

The trust needed to improve its working relationships with trade unions. The general view among the staff representative groups was that the trust was not fully engaging with them and no ongoing dialog was taking place. We found examples were significant changes had been made to working practices without proper consultation. We found that this issue was more significant in non-clinical support staff sectors.

All the staff we spoke to were proud to work for the trust and were committed to delivering excellent patient care.

The trust provided the following breakdown of staff groups by ethnic group.

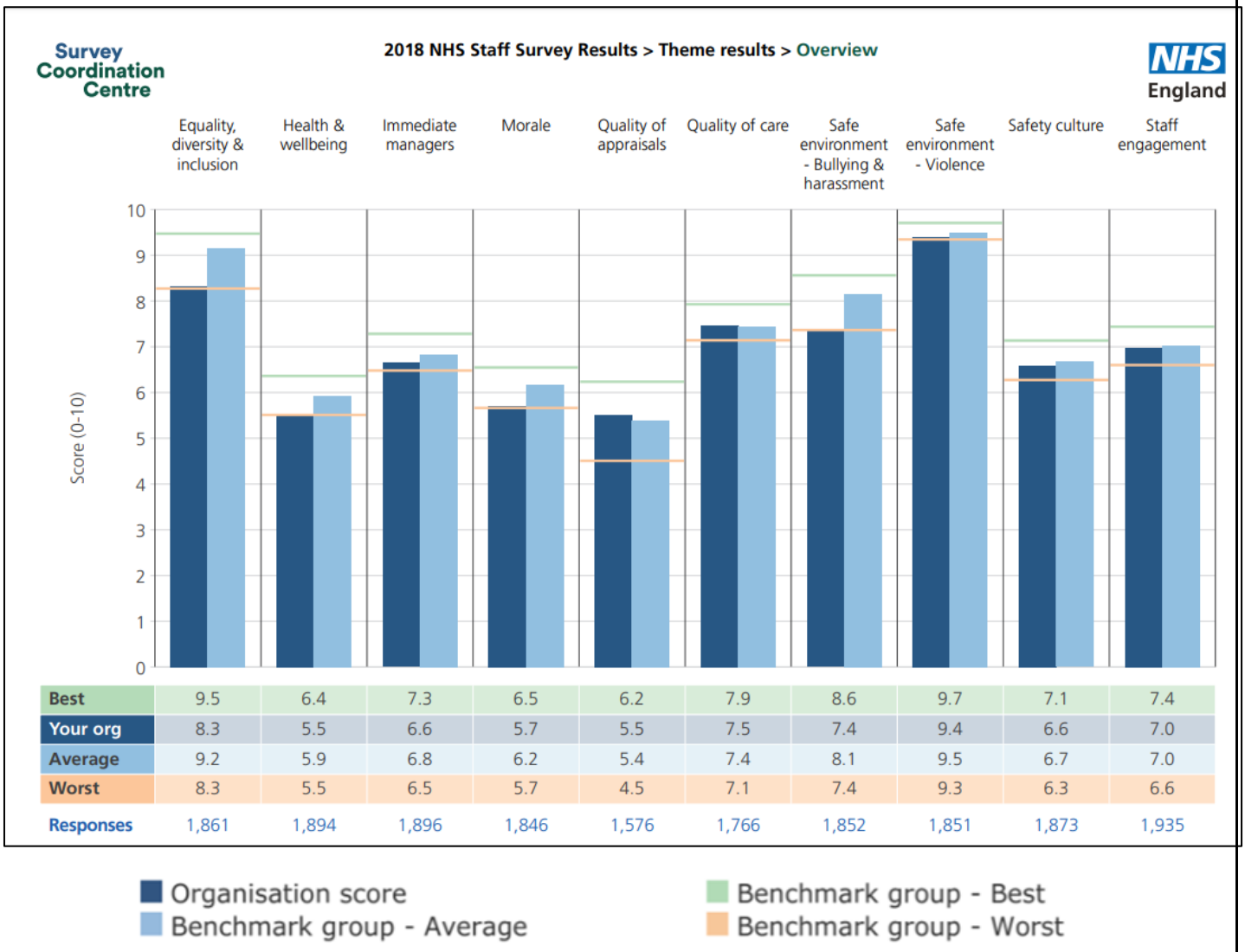
Ethnic group	Medical and dental staff (%)	Qualified nursing and midwifery staff (%)	Qualified allied health professionals (%)
A White - British	35.6%	21.0%	43.4%
B White - Irish	1.9%	5.7%	4.7%
C White - Any other White background	11.6%	7.5%	14.7%
CF White Greek	0.2%	0.3%	0.2%
CQ White ex-USSR	0.2%		
CY White Other European	0.9%	1.7%	0.9%
D Mixed – White & Black Caribbean	0.7%	0.4%	0.4%
E Mixed - White & Black African	0.4%	0.5%	0.2%
F Mixed - White & Asian	1.9%	0.4%	0.4%

G Mixed - Any other mixed background	2.1%	0.5%	0.8%
H Asian or Asian British - Indian	12.5%	2.3%	5.5%
J Asian or Asian British - Pakistani	4.5%	0.4%	0.8%
K Asian or Asian British - Bangladeshi	1.1%	0.6%	0.8%
L Asian or Asian British - Any other Asian background	4.9%	8.2%	1.5%
LA Asian Mixed	0.0%	0.2%	0.0%
LH Asian British	0.2%	0.3%	0.0%
LK Asian Unspecified	0.0%	0.2%	0.0%
M Black or Black British - Caribbean	0.4%	6.9%	2.1%
N Black or Black British - African	2.8%	15.3%	2.3%
P Black or Black British - Any other Black background	0.7%	2.3%	0.0%
R Chinese	2.2%	0.8%	0.8%
S Any Other Ethnic Group	2.8%	3.1%	1.3%
SC Filipino	0.2%	2.7%	0.6%
Undefined	7.3%	18.2%	18.1%
Z Not Stated	5.0%	0.9%	0.8%

(Source: Routine Provider Information Request (RPIR) – Diversity tab)

NHS Staff Survey 2018 results – Summary scores

The following illustration shows how this provider compares with other similar providers on ten key themes from the survey. Possible scores range from one to ten – a higher score indicates a better result.



There were no themes in the 2018 report that were significantly higher (better) when compared to the 2017 survey.
The trust's 2018 scores for the following themes were significantly lower (worse) when compared to the 2017 survey:

- Equality, diversity & inclusion
- Safe environment – bullying & harassment
- Safe environment – violence

(Source: NHS Staff Survey 2018)

Workforce race equality standard

The Workforce Race Equality Standard (WRES) became compulsory for all NHS trusts in April 2015. Trusts have to show progress against nine measures of equality in the workforce.

The scores presented below are indicators relating to the comparative experiences of white and black and minority ethnic (BME) staff, as required for the Workforce Race Equality Standard.

The data for indicators 1 to 4 and indicator 9 is supplied to CQC by NHS England, based on data from the Electronic Staff Record (ESR) or supplied by trusts to the NHS England WRES team, while indicators 5 to 8 are included in the NHS Staff Survey.

Notes relating to the scores:

- These scores are un-weighted, or not adjusted.
- There are nine WRES metrics which we display as 10 indicators. However, not all indicators are available for all trusts; for example, if the trust has less than 11 responses for a staff survey question, then the score would not be published.
- Note that the questions are not all oriented the same way: for 1a, 1b, 2, 4 and 7, a higher percentage is better while for indicators 3, 5, 6 and 8 a higher percentage is worse.
- The presence of a statistically significant difference between the experiences of BME and White staff may be caused by a variety of factors. Whether such differences are of regulatory significance will depend on individual trusts' circumstances.

WRES Indicators from ESR (HR data) (*)	BME Staff	White Staff	Are there statistically significant difference between...	
			BME and White staff?	Last year and this year? (BME staff)
1a. Proportion of clinical (nursing and midwifery) staff in senior roles, band 8a+	5.9%	16.5%	●	-0.3% →
1b. Proportion of non-clinical staff in senior roles, band 8+	3.3%	19.9%	●	0.1% →
2. Proportions of shortlisted candidates being appointed to positions	4.7%	9.7%	●	-12.7% ↓
3. Proportion of staff entering formal disciplinary processes	1.1%	0.9%	○	-0.6% →

WRES Indicators from the NHS staff survey (**)		Proportion of respondents answering "Yes"			Are there significant differences between...		
		BME staff	White staff	All staff	BME and white staff?	This trust and its peer group?	Last year and this year? (BME)
5. Staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months	Trust	35.9%	30.5%	31.8%	●	●	6.9% ↓
	Peer group	*27.9%*	*25.3%*	*26.3%*			
6. Staff experiencing harassment, bullying or abuse from staff in the last 12 months	Trust	36.2%	31.4%	34.1%	●	●	3.7% →
	Peer group	*29.3%*	*23.6%*	*25.1%*			
7. Staff believing that the trust provides equal opportunities for career progression or promotion	Trust	58.3%	83.2%	70.5%	●	●	-3.1% →
	Peer group	*69.5%*	*87.3%*	*84.2%*			
8. Staff experiencing discrimination at work from a manager / team leader or other colleague?	Trust	20.3%	9.5%	14.1%	●	●	3.2% →
	Peer group	*15.6%*	*5.9%*	*7.6%*			

Trust staffing numbers (*)	2018		2017	
9. [BME Voting Board Members] and Board compared to overall staff demographic	[3]	○	[2]	○

Key

- ● Statistically significant or negative finding
- ○ Not statistically significant
- ● Positive finding
- ○ Statistical analysis not undertaken as less than 30 BME staff responded
- ↑ Statistically significant improvement
- → No statistically significant change
- ↓ Statistically significant deterioration

As of March 2019, three of the ESR staffing indicators shown above (indicators 1a to 3) showed a statistically significant difference in score between white and BME staff:

1a. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) clinical roles (5.9% of BME staff compared to 16.5% of White staff). This was not significantly different to the previous year, 2017.

1b. In 2018, BME candidates were significantly less likely than White candidates to hold senior (band 8+) non-clinical roles (3.3% of BME staff compared to 19.9% of White staff). This was not significantly different to the previous year, 2017.

2. In 2018, BME candidates were significantly less likely than White candidates to get jobs for which they had been shortlisted (4.7% of BME staff compared to 9.9% of White staff). This has significantly deteriorated for BME staff in 2018 compared to BME staff in 2017 by 13%.

Of the four indicators from the NHS staff survey 2018 shown above (indicators 5 to 8), all four of the indicators showed a statistically significant difference in score between White and BME staff:

5. 35.9% of BME staff experienced harassment, bullying or abuse from patients, relatives and the public in the past year (2018 NHS staff survey) which was significantly higher when compared to 30.5% of White staff. The score had significantly deteriorated by 6.9% when compared to the previous year, 2017.
6. 36.2% of BME staff experienced harassment, bullying or abuse from staff in the past year (2018 NHS staff survey) which was significantly higher when compared to 31.4% of White staff. This was not significantly different to the previous year, 2017.
7. 58.3% of BME staff believed that the trust provided equal opportunities for career progression and promotion (2018 NHS staff survey) which was significantly lower when compared to 83.2% of White staff. This was not significantly different to the previous year, 2017.
8. 20.3% of BME staff experienced discrimination from a colleague or manager in the past year (2018 NHS staff survey) which was significantly higher when compared to 9.5% of White staff. This was not significantly different to the previous year, 2017.

There were three BME Voting Board Members at the trust, which was not significantly different to the number expected, based on the overall percentage of BME staff.

(Source: NHS Staff Survey 2018; NHS England)

The trust had shown some minor improvements in WRES results. There had been a 4% increase in BME representations in bands 8 and above. The gap between BME and non BME staff being subjected to harassment and bullying had reduced slightly by 1%.

The trust board and senior managers we spoke with acknowledged that there was much more work to do in addressing this inequality amongst their staff. Most staff felt equality and diversity were promoted in their day to day work and when looking at opportunities for career progression.

Friends and Family test

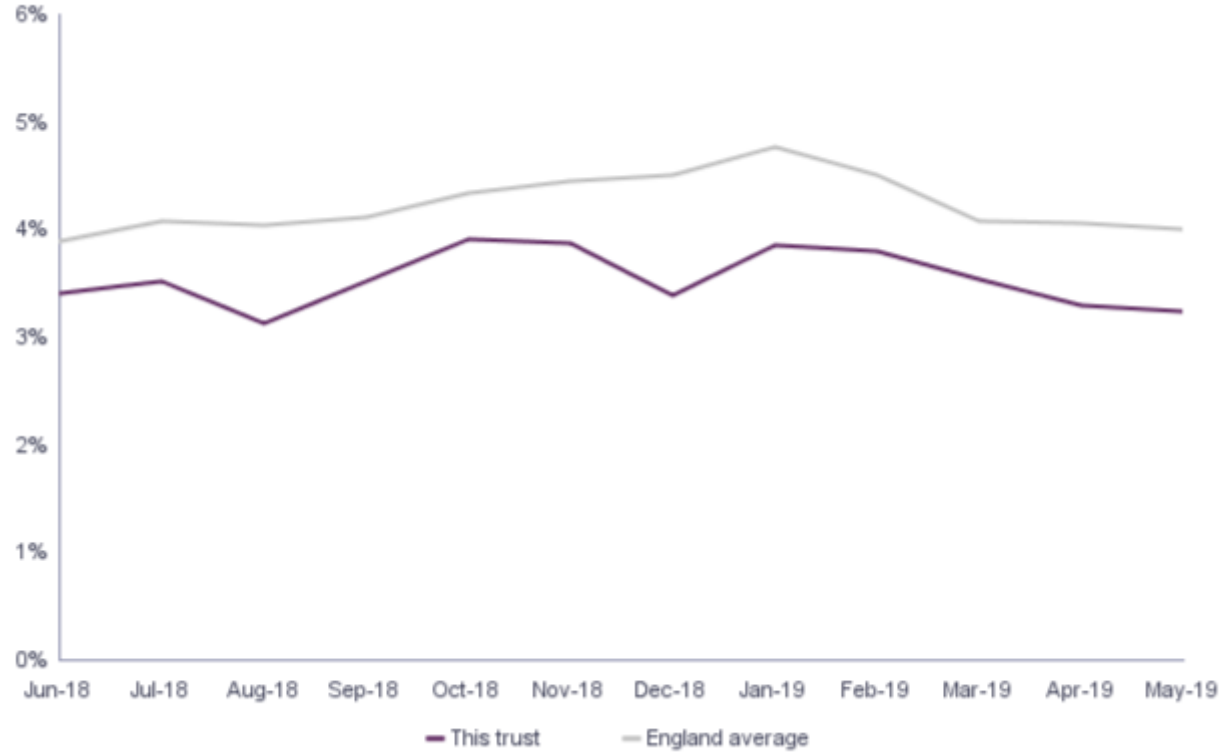
The patient friends and family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

The trust scored between 95.2% and 98.4% between August 2017 and July 2019. The data appeared to be stable with only random variation over the whole period.

(Source: Friends and family test)

Sickness absence rates

The trust's sickness absence levels from June 2018 to May 2019 were below the England average.



(Source: NHS Digital)

Sickness and absence figures were excellent and had substantially improved in the last 12 months.

General Medical Council – National Training Scheme Survey

In the 2019 General Medical Council Survey the trust performed as expected on all of the indicators.

(Source: General Medical Council National Training Scheme Survey)

The trust had appointed a Freedom to Speak Up Guardian and provided them with sufficient resources and support to help staff to raise concerns. The trust had a Speak Up Guardian who worked alongside 19 speak up 'advocates', another eight advocates were about to be trained. The advocates role was to signpost services including the guardian, attempt early de-escalation of issues and raise awareness of the scheme among staff.

The guardian had been trained by the national guardian's office and had also been supported by the trust with time and resources to undertake further development and perform the role. The guardian had direct access to all the board members and felt that their voice was being heard.

There was a dedicated email address for staff to contact the speak up guardian, which the guardian monitored. The speak up guardian attended trust events, walkabouts and staff induction days.

From September 2018 to September 2019, 66 concerns had been raised, 30 were anonymous. Since September 2019, the rate of reporting had increased but the number of anonymous complaints had decreased. Every six months a paper is presented to the board. There was discussion at the board about key themes and how the trust can address them. Of the 66 concerns in the last report, 46 had been around bullying and harassment.

Managers addressed poor staff performance where needed. We found that staff were held to account for their performance and actions in an appropriate way. There was a good balance between supervision and support. Staff we spoke with were clearly held to account by their senior managers, but no one commented that the culture was overbearing.

National Guardian Office had undertaken a review of two closed speak up cases at the trust. The trust had worked with the national office to develop further improvements which have been captured in an action improvement plan.

Staff Engagement

During the inspection we observed humility, openness and a willingness to learn among senior staff.
There had been significant improvements in staff completing the annual NHS staff survey. In 2017 42% completed, in 2018 48% had completed and at the last survey in 2019 the completion rate had increased to 56%.

The trust and 20 other NHS combined community trust engaged an independent research company to undertake their NHS staff survey. The trust shared with us the initial evaluation conducted by this company in advance of the full NHS publication. From this initial evaluation we noted the following keys information:

- This trust had a response rate of 56% compared to a national average of 50%.
- 52% of questions had shown no significant change in response, 1% had shown a deterioration and 37% had shown a significant improvement.
- The trust overall score was ranked 10th out of 21 trusts.
- The trust had the most improved overall score of all 21 trusts.

The trust had an extensive programme of engaging and supporting its staff. Much of this activity was under the title of #caringforthosewhocare. This included:

- Leadership seminar and culture fair.
- Wellbeing events.
- Culture collaborative.
- Mediation and facilitation.
- Simplified, piloted, rolled out appraisal documents.
- Behaviour frameworks.
- Staff charter.
- Reverse mentoring.

- Affina team journey.
- Values based leadership.
- Coaching.

Staff networks were in place promoting the diversity of staff. The trust had staff networks for BME, Disability (known as Whittability) and LGBT. These networks had been running for a number of years but had recently been relaunched to try and increase their visibility and representation. All of these activities were coordinated by the trust development team who we found to be a committed, passionate and capable group of staff.

During the inspection, we met with representative from all the staff networks. All staff were positive about the support given to them by members of the trust board and in particular the CEO. However, some staff told us they were not always 'released' by their managers to attend important network meetings and events. The trust recognised staff success by staff awards and through feedback.

Staff within the pharmacy team had regular appraisals and the pharmacy staff survey results were analysed to look at the results from the pharmacy team. Staff concerns were able to be collated via informal and formal means (e.g. regular team meetings on a weekly basis).

Patients' medicines needs were supported in a number of ways. For example, the trust used feedback from users via patient surveys and questionnaires in outpatients. This led to the trust offering different methods of help to ensure patients medicines needs were met. For example, there was a respiratory pharmacist available to tailor patients' needs via different inhalers.

Governance

The trust had effective structures, systems and processes in place to support the delivery of its strategy including sub-board committees, divisional committees, team meetings and senior manager meetings. All members of the board were present at all key governance meetings and gave clear leadership and direction. The board functioned effectively. However, they recognised that they are still working on being a better board.

The governance framework addressed the need to meet people's mental health needs. We found that the board were aware of the risks and issues faced by patients who were dealing with a mental health condition. The board work with its partners in the community and the local NHS mental health trust to meet the needs of these patients. However, focus and progress needs to be accelerated in this area as we found that there was still more work to do to achieve parity between mental health and physical health patients.

A clear framework set out the structure of ward/service team, division and senior trust meetings. Managers used meetings to share essential information such as learning from incidents and complaints and to act as needed. Day to day operational performance and delivery was delegated to the five ICSU leadership teams, who were given a great deal of autonomy. We found that this approach worked well, and that the ICSU leadership teams had the appropriate skills and experience to make key decisions. These teams had HR and Finance business partners to provide them with expert advice and support in these areas. ISCUs did not have the same level of advice and support on IT issues and we found that IT strategy and delivery were not as clear as other areas within the trust.

There were full board meetings every month which allowed board members regular formal reporting opportunities on the trusts risks and performance. Non-executive and executive directors

were clear about their areas of responsibility. The trust was working with third party providers effectively to promote good patient care. There were regular meetings at board level with other NHS acute and mental health trusts.

Since the last CQC Inspection, the trust has implemented a revised operational structure which comprised of five Integrated Clinical Service Units (ICSUs). Accountability for quality and safety was devolved to ICSU leadership triumvirates - clinical director, director of operations, and associate director of nursing. A written accountability framework set out the relationships between ICSUs, executives and trust board against an integrated governance system of patient safety, patient experience and clinical effectiveness. Each ICSU reported twice a year to the quality committee, and quarterly to the trust executive.

Each ICSU held a monthly board meeting to review quality, performance, finance and workforce. we were told that work was underway to standardise the format of ICSU's quality performance reports following a revision of terms of reference in August 2019.

ICSU risk managers worked with associate directors of nursing and the corporate governance team and met weekly, reviewing new incidents, identifying those for consideration by the serious incident executive approval group (SIEAG) and providing support to incident investigations. The trust has an electronic reporting system in place and promotes a positive reporting culture.

The numbers of reported incidents varied across ICSUs. Support has been given to Emergency and Integrated Medicine to address a serious incident backlog and implementation of action plans.

Serious Incidents (SIs) are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers , staff or organisations are so significant that they warrant investigation to identify the factors that contributed towards the incident occurring and fundamental issues (or root causes) that underpinned these.(NHS England 2015).

The trust senior leaders were positively engaged with Quality and Safety. The SIEAG comprising the executive medical director /associate medical directors, chief nurse chief operating officer, head of quality governance and serious incident (SI) coordinator, met weekly to monitor and review SI investigation reports as defined within the NHSE framework. Where incidents did not meet the criteria to be declared externally to the strategic executive information system (StEIS *) the trust undertakes internal root cause analysis (RCA) to ensure root causes are identified and learning shared.

(*StEIS facilitates the reporting of Serious Incidents and the monitoring of investigations between NHS Providers and Commissioners)

ICSU governance leads described the positive impact of the (newly appointed) medical director on the SIEAG. They described a positive culture, focus on action and learning, encouragement for junior staff to attend in support of learning and development and improved multidisciplinary working and learning across ICSUs.

Never events are serious, largely preventable patient safety incidents that should not occur if healthcare providers have implemented existing national guidance or safety recommendations.

Never Events differ from other Serious Incidents: a Never Event acts as a red flag that an Organisations systems for implementing existing safety advice or alerts may not be robust (NHS Improvement February 2019).

In January 2018 NHS Improvement published a revised Never Events policy and framework. in response to this the trust undertook a never event gap analysis. A key finding was that monitoring of, and assurance of ongoing compliance with patient safety alerts was not robust. This has now been addressed with the implementation of ongoing patient safety alert audit.

To help prevent Never Events a set of new national safety standards for invasive procedures (NatSSIPs) were published in September 2015 and all relevant NHS organisations were instructed to develop and implement their own local standards (LocSSIPs) based on the principles set out in the national standards. The trust has recognised that there is more work to do to develop and embed local guidance and the need for action in this regard has been highlighted in both serious incident and never event investigations. A clinically led steering group reporting to the patient safety committee was established in July 2019 to take this work forward. A LocSSIPs page is now live on the trust intranet.

A quarterly aggregated learning report is presented to the patient safety committee and quality committee providing an update on aggregated learning from complaints, patient advice and liaison service (PALS), incidents, inquests and legal claims. The November 2019 report (Quarter 2, April to September 2019) quotes a 14% increase in patient safety incident reports which is an increase of 38% for the same period in the previous financial year.

Organisations with high levels of incident reporting are generally felt to be more open honest and transparent supporting a culture of continuous learning rather than blame.

Whilst Band 5 Nurses are the highest incident reporters there has been an increase in the number of administrative staff and patients and visitors reporting incidents - patient and visitor incidents are logged by staff.

Top 5 categories Patient Safety Incidents Quarter 2 2019/20

- Pressure Ulcers
- Access, appointment, admission, transfer, discharge
- Security
- Labour/Delivery
- Staffing, facilities, environment

A total of 2,614 incidents were reported of which 2,511 related to Whittington Health, the remainder were external to the trust (e.g. Primary Care, Nursing Home) 1933 were patient safety incidents, of which 94% were no or minimal harm.

Three SIs were declared in November 2019 bringing the total number of reportable serious incidents to 23 since April 2019.

The board was supported by a number of committees which met regularly and reported back to them. These included: audit and risk, workforce assurance, quality, finance and business development, quality, charitable funds and remuneration. In addition, the trust management group met fortnightly and the executive team met weekly. Papers for governance meetings were of a good standard and contained appropriate information. We observed a number of these meetings and found that they were well led, structured and to the point, with clear outcomes.

In August 2016 the new terms and conditions for doctors in training were introduced. This gave trusts the responsibility to ensure that doctors in training have appropriate working hours that

ensure good training, but also ensure quality of care and safety for patients. The trust appointed a 'guardian for safe working hours' to oversee the process and report regularly to the board. They resolved or escalated problems and acted as a champion of safe working hours for junior doctors. The trust was meeting the requirements around exception reporting, board reporting and the junior doctors forum.

We found that trainees were encouraged to report exceptions such as excessive hours or poor training opportunities and the exception reporting levels were good. There was good evidence of exception reports being escalated and acted upon satisfactorily. We were given examples of when effective changes had been made to address rotas and work schedules which had triggered exception reports. The guardian of safe working hours was in the consultation phase with the junior doctors on what to spend the fines.

The trust has consistently delivered its operating plans since 2015/16. On a control total basis, including sustainability and transformation funding (STF), the 2017/18 outturn was a surplus of £5.4m, a £9.1m improvement from 2016/17. This position further improved in 2018/19 to a surplus, including provider sustainability funding (PSF), of £28.2m, which was in part due to the disposal of a non-clinical part of the main hospital site to Camden & Islington NHS FT. The trust plans to deliver its breakeven control total (including PSF) in 2019/20.

The trust's underlying position shows an improving trend from a deficit position of £13.1m to £9.9m – an improvement of £3.2m – between 2015/16 and 2018/19. For the current year, the trust planned underlying deficit is £4.9m, a further improvement of £5m, which the trust is forecasting to meet as at month 7.

The trust effectively managed cash and working capital in 2018/19 and improved its closing position by £21.1m, from 2017/18, to £25.2m. This was due to improved working capital management and receipt of cash proceeds from an asset disposal and PSF. The trust is forecasting to further improve its cash position by £10.3m, to £35.5m in 2019/20.

Medicines optimisation was well integrated into the governance structure for the trust. Medicines incidents reported on the incident reporting system were discussed at the Patient Safety Committee. The committee had a clear and manageable remit and was effective in monitoring medicines incidents, investigations and the sharing of learning.

The Drugs and Therapeutics Committee were responsible for authorising all medicines related to NICE Guidance and Technology Appraisals and this was fed back to the Quality Committee. There were no gaps identified in the reporting lines between the medicines related committees.

The trust had recently strengthened its governance framework on the provision of pharmacy support across its community services. This included, for example, an audit framework which was more focused on identifying medicines management issues at community sites where frequent pharmacy input was not achievable.

Management of risk, issues and performance

The trust had systems in place to identify learning from incidents, complaints and safeguarding alerts and make improvements. The governance team regularly reviewed these systems.

Senior management committees and the board reviewed performance reports. Leaders regularly reviewed and improved the processes to manage current and future performance.

The trust board had sight of the most significant risks and mitigating actions were clear. We found that there was a clear culture of risk identification and reporting throughout the organisation. Staff concerns matched those on the risk register. Staff and committee chairs we spoke with shared a common understanding of the trust's key risks and what mitigation was taking place to reduce them.

Staff had access to the risk register either at a team or division level and were able to effectively escalate concerns as needed.

Where cost improvements were taking place there were arrangements to consider the impact on patient care. Managers monitored changes for potential impact on quality and sustainability. We found that both senior nursing and medical staff were involved in developing and approving CIP plans. Plans were based on patient outcomes first and finance second.

Finances Overview

Financial metrics	Historical data		Projections	
	Previous Financial Year (2017/18)	Last Financial Year (2018/19)	This Financial Year (2019/20)	Next Financial Year (2020/21)
Income	£323.4m	£348.7m	£328.5m	£329.8m
Surplus (deficit)	£5.5m	£28.9m	£0	(£1.7m)
Full Costs	£317.9m	£319.9m	£328.5m	£331.6m
Budget (or budget deficit)	£0.6m)	£22.7m	£0	(£1.7m)

The surplus reported in 2018/19 was lower than the previous year. Projections for the next financial year predict an increase in the deficit to £1.7 million for 2020/21.

(Source: Routine Provider Information Request (RPIR) – Finances Overview tab)

This year, although the trust is forecasting to deliver its plan, it was struggling to deliver cost improvement plans (CIPs) to meet its £12.3m CIP target. To mitigate this shortfall, the trust has identified actions that are non-recurrent in nature and will not address the underlying financial position. For future years, the trust needs to ensure that it has the capacity and capability to deliver CIPs and crucially, turn around its remaining underlying financial deficit (which is on an improvement trajectory) – of £9.9 million as at the end of 2018/19 financial year.

The Use of Resources assessment in November 2019 identified that the trust benchmarks adversely on total workforce costs and reference costs expenditure as a percentage of operating expenditure. The trust attributes this adverse performance, in part, to its organisational form, as an integrated care organisation since its peer group is mostly acute trusts. The trust should therefore identify its integrated care peer group and develop fit-for-purpose benchmarks to support objectivity in its productivity appraisals.

In terms of financial risks, the Use of Resources assessment undertaken by NHSI in November 2019 identified that the trust was finding delivering the current year £12.3 million efficiency savings target challenging. As at September 2019, the NHS trust had only managed to deliver £3 million (48%) out of its £6.2 million half year savings target. This finding is consistent with the trust's financial risk register, as at 15 October 2019, that rated failure to deliver CIPs as likely with

catastrophic impact. The Use of Resources report accordingly recognised the trust CIP identification and delivery processes as an opportunity area for improvement.

The overarching impression of the trust's current financial position is that of maintained good performance over the last 3-year period, and this view was shared, during the Well-Led inspection, by stakeholders across the trust who assess the finance team as very capable.

However, it is important to note that if the trust is to achieve its forecast outturn in 2019/20, it will be the second consecutive year it will have done so using non-recurrent means. This places further emphasis on the need for the trust to further collaborate with system partners to innovate service and patient pathway transformation, and continual engagement with digital solutions for better productivity.

Board Assurance Framework

The purpose of the Board Assurance Framework (BAF) is to set out the trust's strategic objectives and identify risks in relation to the achievement of each strategic objective, along with controls in place and assurances available on their operation. Papers for board meetings and other committees were of a good standard and contained appropriate information. The BAF was fit for purpose.

The trust provided their Board Assurance Framework, which details the below four strategic objectives:

1. Deliver outstanding safe, compassionate care in partnership with patients
2. Empower, support and develop an engaged staff community
3. Integrate care with partners and promote health and well-being
4. Transform and deliver innovative, financially sustainable services

(Source: Trust Board Assurance Framework – April 2019)

Relevant risks and assurances contained within the Board Assurance Framework were reviewed and monitored by the leadership team.

The trust board received the BAF every two months at the same time as the risk register. Members of the senior directors' team were requested to highlight any concerns for the board's attention. The external auditors found that the BAF reflected the trusts risks and the board was fully sighted on it. The NEDs also had a detailed knowledge of the BAF risks and associated frameworks.

There were key controls and actions in place. Key actions and mitigations plans were recorded and followed up in a timely way. The inspection found good links across the Board sub committees i.e. Quality, Audit and Finance Committees – with overlapping membership that ensures discussions are joined up and duly escalated to board where necessary. The trust has a clear Accountability Framework that sets out, internal controls, regular monthly monitoring and self-assessment, and quarterly formal reviews (with escalation to monthly where indicated).

Trust corporate risk register

The trust provided a document detailing their four highest profile risks. Each of these have a current risk score of 12 or higher.

ID	Description	Risk score (current)	Risk level (target)	Last review date
1	Failure to provide care which is 'outstanding' in being consistently safe, caring, responsive, effective or well-led and which provides a positive experience for our patients may result in poorer patient experience, harm, a loss of income, an adverse impact upon staff retention and damage to organisational reputation.	12	6	March 2019
4	Failure to recruit and retain high quality substantive staff could lead to reduced quality of care, and higher costs (e.g. nursing, junior doctors, medical posts).	12	8	March 2019
14	Failure to provide robust urgent and emergency pathway for people with mental health care needs results in poor quality care for them and other patients, as well as a performance risk.	12	4	March 2019
17	That the culture of the organisation does not improve, and bullying and harassment continue, such that retention of staff is compromised, staff morale is affected and ultimate patient care suffers as a result.	12	4	March 2019

(Source: Board assurance framework)

The Medical Director's report to the Board December 2019 states that the trust is continuing to review and improve how learning from incidents is shared and embedded to ensure risks are mitigated and areas for improvement are identified. This is linked to the trust corporate risk register (Risk 636) ''Create a robust SI learning process across the Trust ''.

Medical staff training levels

Module	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Equality and diversity	278	485	57.3%	90%	No
Fire safety	297	485	61.2%	90%	No
Health and safety	277	485	57.1%	90%	No
Infection prevention and control	269	485	55.5%	90%	No
Information governance	287	485	59.2%	90%	No
Moving and handling	227	485	46.8%	90%	No
Resuscitation	354	485	73.0%	90%	No
Risk management / duty of candour	322	485	66.4%	90%	No
Safeguarding adults level 1	485	485	100.0%	90%	Yes
Safeguarding adults level 2	237	479	49.5%	90%	No
Safeguarding children level 1	5	6	83.3%	90%	No
Safeguarding children level 2	181	396	45.7%	90%	No
Safeguarding children level 3	47	83	56.6%	90%	No

(Source: trust PIR)

Data provided by the trust showed poor mandatory training completion levels for its medical staff.

The trust had a system for the management of medicines safety alerts. This process was overseen by the trust Drugs and Therapeutics Committee. Action plans were produced and copies of the trust medicines incident policy were accessible to staff via the intranet. Staff across the trust knew how to use the Datix® system to report medicines incidents. All medicines incident reports were sent to the pharmacy department to review. All medicines incidents reported on Datix® were alerted to the trust's medicines safety officer to review. Medication incidents reported as moderate harm and above were additionally alerted to the chief pharmacist. Medicines incidents relating to Controlled Drugs were additionally alerted to the chief pharmacist and trust controlled drugs accountable officer. The medicines safety group, a multidisciplinary sub group of the patient safety committee and drugs and therapeutics committee. would review all significant incidents and learning from these and support ongoing actions required to enhance safety arrangements with regards medicines.

Outcomes were discussed with team members, including prescribers and ward pharmacists, along with 'Medicines Matter' bulletins sent out to wards. This ensured that learning was disseminated to all staff.

The trust had a pharmacy risk register. Current concerns voiced by the Chief Pharmacist included the storage of medicines in high temperatures on certain wards. In order to mitigate this risk, the Chief Pharmacist has put a bid to the trust to procure temperature-controlled medicines cabinets, prioritizing those with high temperatures first.

Information management

Staff said they had access to all necessary information and were encouraged to challenge its reliability. Team managers had access to a range of information to support them with their management role. This included information on the performance of the service, staffing and patient care.

The trust was aware of its performance through the use of key performance indicators and other metrics, they were in the process of standardising the information and dashboards used across the individual integrated clinical service units (ICSUs). This data fed into a governance framework. Information was in an accessible format, timely, accurate and identified areas for improvement. The data provided at the board level allowed a direct comparison and could be used to support a better understanding across the teams and ICSUs.

The trust used external hospital benchmarking tools, including 'Model Hospital' tool or data collected by the NHS Digital. The trust used Model Hospital to track and improve their productivity and efficiency. Model Hospital is a digital information service designed to help NHS providers to improve their productivity and efficiency.

The board received information on service quality and sustainability. The data available to inform decision making was easy to understand and appropriately signposted key risks to both the executive team and the nonexecutive directors. The board and senior staff expressed confidence in the quality of the data and welcomed the challenge.

Information was in an accessible format, timely, accurate and identified areas for improvement.

The trust participated in the "Global Digital Exemplar (GDE) – Fast Follower Programme". GDE was developed in response to the NHS 'Five Year Forward View', originally published in 2014, and aimed to support the growth of digitalisation amongst NHS providers. The trust hoped it would help to transform their current clinical IT infrastructure and develop more efficient systems. The trust

involved staff in the project including clinicians and allied health professionals to ensure the design was fit for purpose and delivered set objectives such as better access to information and improved communication in between systems and community partners. The GDE project was overseen by the trust's digital programme board that reported to the information governance committee.

Some of the initiatives related GDE programme included the introduction of electronic vital signs observation tools. These incorporated alerts and improved identification of and response to deteriorating patients, enabling faster treatment. The trust was also working towards the integration of electronic care records and systems used across various clinical settings (primary, community and mental health care settings) and other improvements related to information accessibility improvements. They learned from other NHS trusts previously involved in the implementation of those systems and shared their experience with other organisations that were to undertake the transition.

The board and senior staff expressed confidence in the quality of the data. Senior leadership teams told us that the quality of information was appropriate and unified across the organisation. Available data allowed to monitor real-time performance at the emergency department or bed state dashboard. The workforce dashboard informed of training completion rates, appraisal rates or absence information. The trust incorporated this information into quality dashboards and performance reports. Those summarised the trust's performance against key national targets and other locally set trajectories or performance indicators. This information was shared with ICSU leaders and was discussed at the ICSU's board meetings or quarterly meetings with a member of the finance team. It was also shared with the trust board and its committees where relevant.

Leaders submitted notifications to external bodies as required. CQC and external bodies such as the CCG and NHSi found the trust to be open and had informed them of any issues they were required to report. Reports and investigations were submitted to CQC promptly and were through and robust.

Staff had access to the IT equipment and systems needed to do their work. IT systems and telephones were working well, and they helped to improve the quality of care. The trust had a capital programme which included IT equipment exchange. Leaders understood that staff needed to be provided with efficient IT systems to improve productivity and ensure good and effective patient's care and treatment delivery.

The trust learned from data security breaches. The trust submitted notifications to external bodies, such as the Information Commissioner's Office, as required. When they experienced a personal data breach they considered whether this posed a risk to people and the likelihood and severity of the risk to people's rights and freedoms, following the breach. They informed patients concerned and put actions in place to prevent future occurrences. A data breach is a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data. The trust used recognised assessment tool to determine if breach needed to be reported under the Privacy and Electronic Communications Regulations.

In October 2019 the trust undertook a review of the data security and protection as advised by the National Data Guardian (NDG). This review aimed to identify gaps in controls over data protection and security as identified by the NHS General Data Protection Regulation (GDPR) checklist. The review confirmed there were processes for appropriately managing data access through limiting the access of staff and revoking this when no longer required and to address security and data breach risk. The internal auditors rated both information governance and cybersecurity with significant assurance (June 2019). They recommended a low priority action to monitor third party

performance of their patching schedules. In response, the trust undertook a programme of upgrading operating systems in 2019.

Information governance systems were in place including confidentiality of patient records. The trust had nominated a Caldicott guardian who was aware of their responsibilities and oversaw procedures affecting access to person-identifiable health data. Caldicott guardian is a senior person responsible for protecting the confidentiality of people's health and care information and making sure it is used properly.

The trust's chief clinical information officer provided leadership and management of information and communications technology and information development activity to support the safe and efficient design, implementation and use of informatics solutions to deliver improvements in the quality and outcomes of care.

The trust had also nominated a senior information risk owner (SIRO) who was an executive director (Chief Operating Officer) with overall responsibility for an organisation's information risk policy. The SIRO was accountable and responsible for information risk across the organisation. They chaired the information governance committee, which reported to the audit and risk committee, and line managed the information governance officer responsible for oversight of the subject access requests (SAR) and freedom of information requests (FOI). Those requests allow individual access to information held by public authorities (FOI) or obtain records related to their personal information (SAR).

There was a pharmacy scorecard used to monitor activity (e.g. medicines safety incidents by site and degree of harm). This data was used to identify areas that needed more pharmacy staff intervention with the trust.

The Pharmacy department monitored the Service Level Agreements with regards to Homecare arrangements and the Outpatients Pharmacy with regular KPIs and ensured effective oversight of these providers.

Regular medicines audits were completed, including the following audits; Controlled Drugs, missed doses, medicines safety and security, antibiotics and medication safety metrics based on NICE guidance/Technology Appraisals (TAs)' These ensured that the pharmacy department were able to monitor and manage the risks associated with the safe and effective use of medicines.

Engagement

The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives. Since our last inspection the trust had revised its engagement strategy to increase the breadth of engagement activity. For example, they had introduced a community newsletter and held a number of community engagement events.

Patients, staff and carers were able to meet with members of the trust's leadership team and governors to give feedback. There were a number of active patient groups such as, Maternity Voices, CYP 15 (young people) and the mental health suite design group. There was evidence that these groups had taken patients views into account in the design of services. The trust had a structured and systematic approach to engaging with people who use services, those close to them and their representatives across all sectors.

The trust sought to actively engage with people and staff in a range of equality groups. However, we found that ancillary support staff were not as engaged as clinical staff in development within the trust.

The trust was actively engaged in collaborative work with external partners, such as involvement with sustainability and transformation plans. The trust was using its status as an integrated trust to work with community partners in the development and delivery of services for the benefit of patients.

The trust had actively commissioned local groups to led and support public engagement work. For example, they had commissioned Bridge Renewal Trust, Manor Gardens and Healthwatch to help them in service design and improvement activity.

The trust has undertaken work to target people affected by homelessness or at risk of homelessness.

Following this a number of initiatives had taken place to:

- change how our clinical staff think about homelessness and why it is a health care issue
- change how trust staff work with people who are homeless or at risk of homelessness
- work collaboratively with and learn from specialist homelessness teams.

As a result of the interest, engagement and commitment from staff following a Grand Round focusing on Homelessness was held in May 2019, which included learning from the death of a woman who was homeless, a Homelessness Pathway Working Group was set up.

Learning is also shared from working with other agencies including the Home Office Modern Slavery team using the National Referral Mechanism, the Salvation Army, Stop the Traffik and Groundswell.

Feedback from individuals and teams of patient stories, suggests that the homelessness quality improvement work has resulted in an improved experience for a number of patients who are homeless.

The trust has a significant and active psychology department that works as part of the multidisciplinary team to improve patient care. Examples of this included;

Psychology led reflective practice sessions

In response to a request for wellbeing support by core medical trainees, the lead CHP psychologist facilitated and evaluated three reflective practice sessions that focused on addressing concerns about burnout. Feedback identified the high value and importance of these sessions for participants. (Abstract of findings accepted for a poster by Royal College of Physicians Annual Conference Medicine 2020). Following this pilot study, the trust has now funded monthly psychology-led reflective practice sessions for the core medical trainees.

C-Factor – Macmillan Innovation award winner 2019

The psychology team recently won the 2019 Macmillan Innovation Award for a new group entitled C-Factor, designed by the Cancer Care psychologist and supported by MDT colleagues. Using a mix of drama and psychology, therapy access was increased for ‘hard to reach’ service users who rated this intervention as extremely helpful including enabling them to feel less alone with their cancer and more engaged with their lives.

The previous trust chair has set up a community forum that was aimed at engagement with a wide cross section of the local community. The forum had a page on the trust website. We noted that the last newsletter had been in July 2019 and the newsletter before this was in 2017.

Communication systems such as the intranet, internet and newsletters were in place to ensure staff, patients and carers had access to up to date information about the work of the trust and the services they used. The systems also allowed people to raise concerns electronically. The trust was very active on social media and used these to communicate strategic and practical information to patients and the public.

The Chief Pharmacist for the trust was responsible for communicating and sharing medicines related information to the leadership team. Other members of the pharmacy department engaged with staff members through a variety of mechanisms, for example through DTC and Medicines Safety Committees and the ICSU board. In addition, they published regular medicines bulletins based on medicines safety themes identified.

The pharmacy team engaged with patients through several ways. For example, in certain areas such as anticoagulation they provided direct advice to patients to ensure that they adhered to their medicines and knew how to take them safely.

The pharmacy team engaged with external providers by a variety of means. For example, they were part of the North Central London STP Network which sought best practice on issues such as the procurement of high cost drugs in an effective manner. This enabled patients to receive these medicines approved by NICE.

Learning, continuous improvement and innovation

The trust took appropriate learning and action as a result of concerns raised. The trust had excellent systems for learning from deaths, SIs and other incidents. The trust actively sought to participate in national improvement and innovation projects. The trust had refreshed its research strategy and had increasing levels of participation in clinical research.

As part of our inspection methodology we reviewed a sample of Sis, Never events and death reviews to assess the quality of the trust processes:

SI Review

A sample (six) of completed SI reports were reviewed. All were well written with completed action plans and evidence of Duty of Candour and feedback to staff.

Good practice of note is evidence of awareness of and cross reference to previous similar incidents and exploration of effectiveness of previous actions and embedded learning

In one report there was evidence of cross reference to patient experience concerns in a service as a result of which a larger piece of work was undertaken in a ‘Look Back’ exercise.

This is good practice and demonstrates oversight of variety of routes by which potential safety issues may be identified

Never Event Review

All six recent Never events were reviewed:

- Unintentional connection of patient requiring Oxygen to Air flowmeter (two)
- Wrong selection of orthopaedic fixation plate (two)
- Wrong side nerve block (two)

Unintentional connection of patient requiring Oxygen to Air flowmeter (two)

One case was retrospectively identified as a Never Event on publication of NHS guidance. A root cause in both instances was failure to implement and adhere to recommendations of the National patient Safety Alert 2016.

As a result, the trust undertook a Never Event and Patient Safety Alert Gap Analysis .The Medical Director was the executive lead for this work and presented a paper to the trust board in November 2019

Key next steps:

- Safety Alerts annual audit to be included as part of the annual Safety Alert report to the Quality Committee
- Safety Alert Action plans to include section for ongoing monitoring which will enable annual audit.

Wrong selection of orthopaedic fixation plate

In February 2019 NHSI issued a Patient Safety Alert relating to the use of correct plates in fixation of shaft fractures and required retrospective review of imaging of patients who had undergone this procedure. 287 cases were identified of which two had had incorrect plates. We found that full duty of candour was evidenced and robust actions in line with NHSI recommendations had been put in place.

Wrong side nerve block

LocSSIPs implementation and monitoring of local guidelines in all areas where in use.

A further Never event was reported to the trust board in November 2019. Whilst local guidance was in place, investigation highlighted human factors issues. As a result, the trust was focusing on improving human factors awareness, including linking with training offered by UCL Partners.

All investigations were completed to a good standard. Duty of Candour was evidenced together with details of immediate actions following the detection of each incident

All final investigation reports are reviewed at the SIEAG meeting. The ICSU Associate Director of Nursing or representative attended the meeting when an investigation from their services is being presented. The remit of the Group is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with recommendations. The panel discusses lessons learnt and actions to prevent future harm. On completion of the report the patient and / or relevant family members receive a final outcome letter highlighting the key findings of the investigation actions taken and planned to improve services. A ‘being open’ meeting is offered in line with Duty of Candour recommendations.

This approach supports the trusts commitment to being open and learning from mistakes.

We saw evidence that information on and learning from Serious Incidents, Never Events, Patient Safety Alerts complaints and Deaths is shared throughout the trust by a number of means including ICSU Boards, Trust Management Group, Trust Board, Ward and Departmental Meetings, Safety Huddles, Big 4 (Theatres),Message of the week (Maternity),10@10 (Emergency Department) monthly Patient Safety Forums, Trust wide e mails and Safety Bulletins ‘Spotlight on Safety’(electronic and hard copy), and weekly Grand Round. Other learning opportunities in the Trust include Swartz Rounds and a Patient Safety Forum for all junior staff.

In the November/ December 2019 edition of Spotlight on Safety three learning from incidents case studies are briefly detailed with clearly stated learning points and changes to practice. In response to a patient safety alert raised by NHS Improvement in May 2019 regarding the assessment and management of babies who were accidentally dropped in hospital, the trust has highlighted the issue and implemented a number of actions including

- Development of a Standard Operating Procedure (SOP)
- Staying overnight information
- Going Home talk
- Multidisciplinary staff advise parents to avoid walking on the wards without shoes or socks

The Patient Safety page on the trust intranet has been updated and is now clearly linked to key resources e.g. RCA tools page, Spotlight on Safety bulletin and patient safety case studies as well as linking to the newly created LocSSIPs page referenced earlier.

The trust also posts the quarterly aggregated learning reports and SI reports, the annual never event gap analysis reports and learning from Grand Round sessions. Case studies linking to learning from Clinical claims are also included, evidence that The Trust promotes a culture of openness and learning and strong focus on safety.

Learning from Deaths

Systems to identify and learn from deaths were effective. The Learning from Deaths (LFD) Policy was clearly written and reflects 'National Guidance on Learning from Deaths, National Quality Board March 2017'.

This guidance was published in response to several high-level reviews which concluded that learning from deaths was not being given sufficient priority in some NHS organisations, as a result there were missed opportunities to improve NHS services and include patient and family experience as part of the review process.

The policy includes a monitoring, compliance and effectiveness framework which is evidence of good practice and links LFD to the SI process and ICSU governance.

Examples of proformas attached to the policy provide clarity for staff in terms of each stage after death.

The trust Hospital Standardised Mortality Rate (HSMR) and Summary Hospital Level Mortality Indicator (SHMI) have both been lower than expected since 2004/05

HSMR an overall indicator which compares hospitals mortality rate with average national figure. A ratio of less than 100 indicates a lower than national average rate. This trusts July 2019 figure was 87.3.

SHMI – this is not a measure of quality of care but meant as an indicator which may suggest the need for further investigation. April 2019 National figure was 1.0. This trusts figure was 0.77.

The Executive Medical Director presents a quarterly LFD report to the Board, key actions and learning from 19/20 quarter 4 report presented November 2019

- Revised foetal movement and CTG monitoring checklist
- Clearer referral pathways to (out of trust) cardiothoracic services

- Review of ~neck of femur pathway
- Revised process for seeking patient information when called by London Ambulance ahead of patient transfer. (this was a Future Prevention of Death notice from the Coroner)

LFD has informed QI and Clinical Audits via the Deteriorating Patient Committee, work on Discharge Summaries and a refresh of the falls QI work programme and training and education undertaken in

- Maternity- Staff skills and escalation
- Emergency department -Refresh of training programme
- Work to enable earlier referrals to Palliative care
- Surgery -Revised education programme for Venous Thrombo-embolism (VTE) and National Emergency Laparotomy Audit (NELA) scoring

LFD is led by an Associate Medical Director who has established an Education approach to completing Structured Judgement reviews (SJRs) Trainee Doctors are trained in SJR and receive supervision from seniors and AMD .This model promotes involvement and learning which feeds through to departmental and ICSU governance as well as wider learning as above.

(A sample (6) SJR's were reviewed – all of a very high standard)

In the last year a quarterly Mortality Review Group has been established and work is underway across the sector to establish the Medical Examiner role by April 2020

Patient Safety Quality Improvement (QI) projects

There were organisational systems to support improvement and innovation work.

The trust wide QI methodology is the Institute for Healthcare Improvement (IHI) Plan Do Study Act (PDSA) approach and over 100 projects are in place mapped to strategic objectives.

The QI steering group reports to the Quality Committee. We were told that 208 staff have had face to face QI training and over 300 staff have completed QI e- learning.

The trust recently launched #HelloMyNameIs (Spotlight on Safety November/December 2019) as a QI project. In addition to improving Patient experience the initiative underpins promotion of an open safety culture, whereby ''being able to clearly see each other's first names will make it easier to speak up and stop any potential errors, save valuable time in critical situations, and address communication issues which feature in adverse events .70% of adverse events are related to communication. '

Other QI projects include a Stop Falls campaign and improving communication in discharge planning.

The trust is represented at the sector Patient Safety Network where learning is shared across Healthcare providers.

A new Associate Director for Research and Innovation is refreshing the Trust research strategy. 1077 patients in 49 National Institute for Health Research (NIHR) studies last year (50% increase on prior year).

Complaints process overview

The trust was asked to comment on their targets for responding to complaints and current performance against these targets for the last 12 months.

Question	In days	Current performance
What is your internal target for responding to complaints?	3	99%
What is your target for completing a complaint	25	86%
If you have a slightly longer target for complex complaints please indicate what that is here	40	77%
Number of complaints resolved without formal process in the last 12 months?	2,261 (August 2018 to July 2019)	

(Source: Routine Provider Information Request (RPIR) – Complaints Process Overview tab)

Number of complaints made to the trust

From 01 August 2018 to 31 July 2019, the trust received a total of 324 complaints. The highest number of complaints were for outpatients (20.4%), followed by urgent and emergency care (16.4%) and medical care (15.7%).

Core Service	Number of complaints	Percentage of total
Outpatients	66	20.4%
Urgent and emergency services	53	16.4%
Medical care (including older people's care)	51	15.7%
Adults community	35	10.8%
Maternity	30	9.3%
Surgery	22	6.8%
Services for children and young people	16	4.9%
Gynaecology	16	4.9%
Provider wide	13	4.0%
Community, children, young people and families	7	2.2%
Diagnostics	5	1.5%
Other	4	1.2%
Community dental	3	0.9%
Specialist community mental health services for children and young people	2	0.6%
Critical care	1	0.3%
Total	**324**	**100%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Compliments

From August 2018 to July 2019, the trust received a total of 365 compliments. The highest number of compliments were for the community adults core service, with 18.1% of total compliments, followed by medical care (17.0% of compliments) and urgent and emergency care (16.2%).

A breakdown by core service can be seen in the table below:

Core service	Number of compliments	Percentage of total
Adults community	66	18.1%
Medical care (including older people's care)	62	17.0%
Urgent and emergency services	59	16.2%
Surgery	46	12.6%
Outpatients	27	7.4%
Provider wide	25	6.8%
Maternity	21	5.8%
Other	15	4.1%
Diagnostics	14	3.8%
Gynaecology	13	3.6%
Community children, young people and families	9	2.5%
Critical care	2	0.5%
End of life care	2	0.5%
Services for children and young people	2	0.5%
Community dental	1	0.3%
Specialist community mental health services for children and young people	1	0.3%
Total	**365**	**100%**

(Source: Routine Provider Information Request (RPIR) – Compliments)

We found that staff had learned from medicines related safety incidents and could demonstrate action taken as a result. For example, due to a theme of incidents where patients were admitted for bleeding after taking direct oral anticoagulants (DOACs) and non-steroidal anti-inflammatories (NSAIDs) together, the trust focused on providing individual patient counselling to ensure patients avoided taking these combinations of medicines together. Staff were made aware of the changes in various ways, for example via a medicines safety bulletin that had been circulated from the pharmacy team.

The pharmacy department told us about an innovative service involving placing their specialists in GP practices to look at supporting people' medicines needs in the community. The aim of the project was to lower the rate of avoidable admissions to the trust. In addition, the department currently funded several members of staff to undertake further specialist training, for example a PhD student.

The chief pharmacist felt that these service improvements were resourced appropriately as the department had the support from executive level which had been formally evaluated.

Accreditations

NHS trusts are able to participate in a number of accreditation schemes whereby the services they provide are reviewed and a decision is made whether or not to award the service with an

accreditation. A service will be accredited if they are able to demonstrate that they meet a certain standard of best practice in the given area. An accreditation usually carries an end date (or review date) whereby the service will need to be re-assessed in order to continue to be accredited.

The table below shows which of the trust's services have been awarded an accreditation.

Accreditation scheme name	Accreditation summary
Clinical Pathology Accreditation and it's successor Medical Laboratories ISO 15189	Accreditation maintained and all areas passed.
Quality network for inpatient CAMHS (QNIC)	Simmons House accredited for the period 4 July 2017 to 4 July 2020.
Psychiatric Liaison Accreditation Network (PLAN)	ILAT team accredited in August 2018 by the Royal College of Psychiatrists.

(Source: Routine Provider Information Request (RPIR) – Accreditations tab)

Acute services

The Whittington Hospital

Magdala Avenue
London
N19 5NF

Tel: (020) 7288 3939

www.whittington.nhs.uk

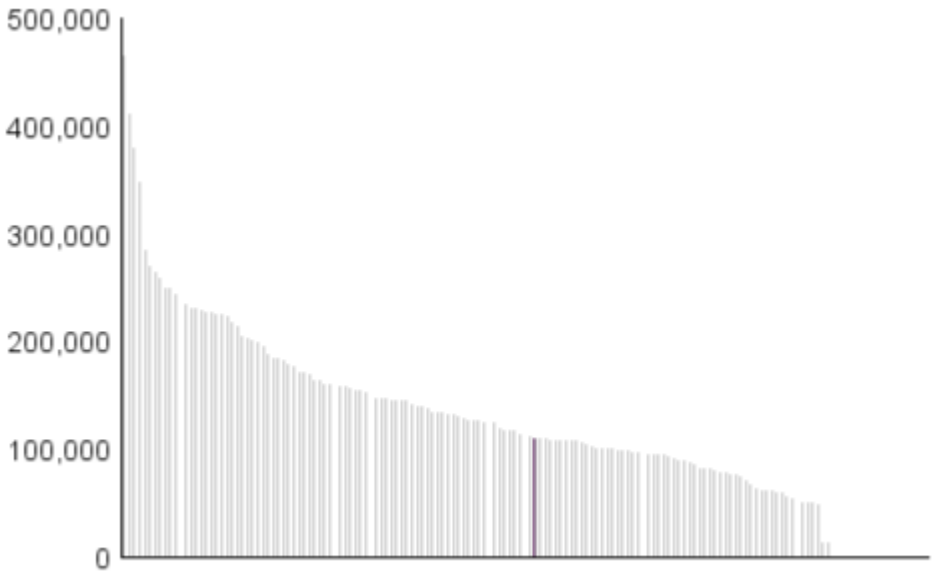
Urgent and emergency care

Facts and data about this service

Whittington Health NHS Trust has an emergency department and urgent care centre, both based at the Whittington Hospital.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

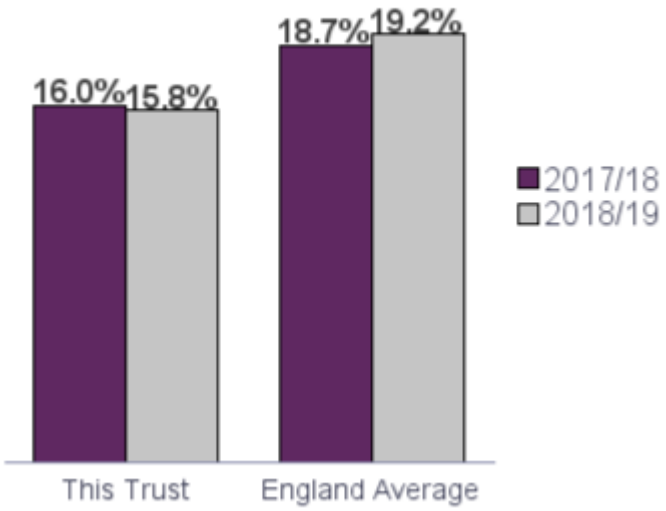
Total number of urgent and emergency care attendances at Whittington Health NHS Trust compared to all acute trusts in England, July 2018 to June 2019.



From July 2018 to June 2019 there were 109,365 attendances at the trust's urgent and emergency care services as indicated in the chart above.

(Source: Hospital Episode Statistics)

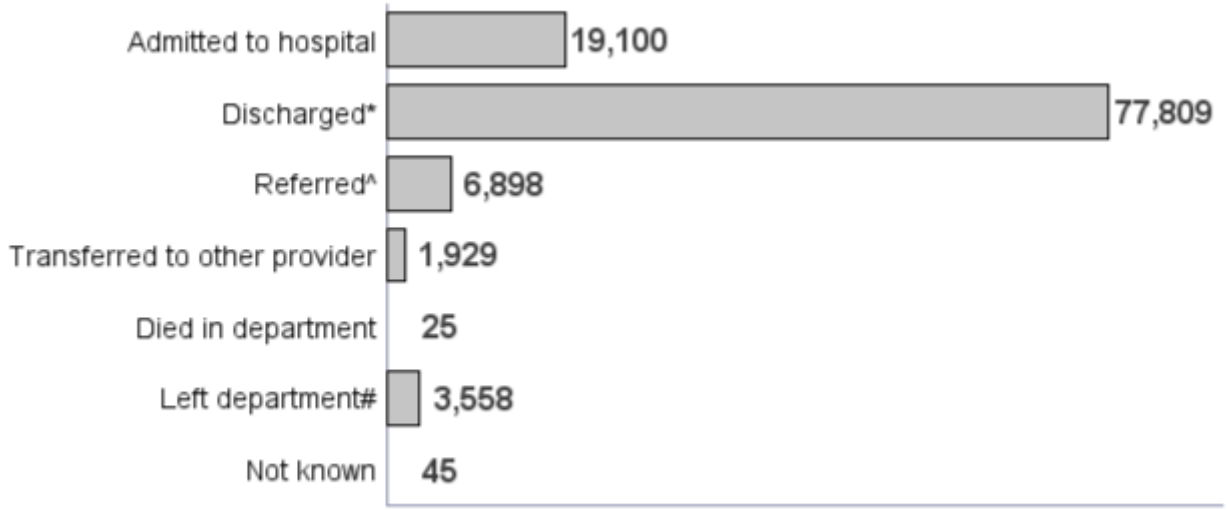
Urgent and emergency care attendances resulting in an admission



The percentage of A&E attendances at this trust that resulted in an admission remained similar in 2018/19 compared to 2017/18. In both years, the proportions were lower than the England averages.

(Source: NHS England)

Urgent and emergency care attendances by disposal method, from July 2018 to June 2019



* Discharged includes: no follow-up needed and follow-up treatment by GP
^ Referred includes: to A&E clinic, fracture clinic, other OP, other professional
# Left department includes: left before treatment or having refused treatment

(Source: Hospital Episode Statistics)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training for nurses in key skills including the highest level of life support training and made sure they completed it. However, not all doctors completed the mandatory training required to keep their knowledge and skills up to date.

The trust set a target of 90% for completion of mandatory training.

A breakdown of compliance for mandatory training courses as at 31 August 2019 at Whittington Hospital for qualified nursing staff in urgent and emergency care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Risk management / duty of candour	115	122	94.3%	90%	Yes
Fire safety	114	122	93.4%	90%	Yes
Health and safety	112	122	91.8%	90%	Yes
Moving and handling	108	122	88.5%	90%	No
Conflict resolution	107	122	87.7%	90%	No
Resuscitation	107	122	87.7%	90%	No
Equality and diversity	106	122	86.9%	90%	No
Infection prevention and control	106	122	86.9%	90%	No
Information governance	103	122	84.4%	90%	No

In urgent and emergency care the 90% target was met for three of the nine mandatory training modules for which qualified nursing staff were eligible.

A breakdown of compliance for mandatory training courses as at 31 August 2019 at Whittington Hospital for medical staff in urgent and emergency care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Health and safety	16	23	69.6%	90%	No
Infection prevention and control	16	23	69.6%	90%	No
Equality and diversity	15	23	65.2%	90%	No
Risk management / duty of candour	15	23	65.2%	90%	No
Information governance	14	23	60.9%	90%	No
Moving and handling	14	23	60.9%	90%	No
Resuscitation	13	23	56.5%	90%	No
Conflict resolution	12	23	52.2%	90%	No
Fire safety	11	23	47.8%	90%	No

In urgent and emergency care the 90% target was not met for any of the nine mandatory

training modules for which medical staff were eligible.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Mandatory training was comprehensive and met the needs of patients and staff.

Clinical staff completed training on recognising and responding to patients with learning disabilities, autism and dementia. The mental health liaison service provided training sessions for ED staff in mental health. Staff felt the training offered by the trust was of good quality and met their individual training needs.

Managers monitored mandatory training and alerted staff when they needed to update their training.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Most of the nursing staff had training on how to recognise and report abuse and they knew how to apply it. The training completion rates amongst doctors did not meet the provider's set target.

Most of the nursing and medical staff received training specific for their role on how to recognise and report abuse. The trust set a target of 90% for completion of safeguarding training. At the time of the inspection, records indicated safeguarding training level compliance above the target level amongst nursing staff.

A breakdown of compliance for safeguarding training courses as at 31 August 2019 at Whittington Hospital for qualified nursing staff in urgent and emergency care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	122	122	100.0%	90%	Yes
Safeguarding children level 3	73	82	89.0%	90%	No
Safeguarding adults level 2	107	122	87.7%	90%	No
Safeguarding children level 2	32	40	80.0%	90%	No

In urgent and emergency care the 90% target was met for one of the four safeguarding training modules for which qualified nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as at 31 August 2019 at Whittington Hospital for medical staff in urgent and emergency care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)

Safeguarding adults level 1	23	23	100.0%	90%	Yes
Safeguarding children level 2	4	6	66.7%	90%	No
Safeguarding adults level 2	13	23	56.5%	90%	No
Safeguarding children level 3	8	17	47.1%	90%	No

(Source: Routine Provider Information Request (RPIR) – Training tab)

In urgent and emergency care the 90% target was met for one of the four safeguarding training modules for which medical staff were eligible.

Less than 50% of staff had completed the safeguarding children level 3 module which equated to nine members of staff not completing the training.

The staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff were aware of issues related to female genital mutilation (FGM), also known as female genital cutting and female circumcision, and knew how to respond to them. They FGM training was incorporated in the mandatory safeguarding training.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the department.

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept the equipment and the premises visibly clean.

There were housekeeping staff responsible for cleaning all areas. Patients and relatives told us they were satisfied with the level of cleanliness in the department. Areas we visited were tidy, clean, and uncluttered.
We observed that sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013.

Clinical and domestic waste bins were available and clearly marked for appropriate disposal. We noticed information explaining waste segregation procedures and waste segregation instructions.

There was sufficient access to hand gel dispensers, handwashing, and drying facilities. Hand washing basins had sufficient supplies of soap and paper towels. We saw displayed signage prompting people to wash their hands and gave guidance on good hand washing practice. Personal protective equipment such as disposable gloves and aprons were readily available in all areas. Staff followed infection control principles including the use of personal protective equipment.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. However the environment did not provide therapeutic environment for patients with poor mental health. Staff were trained to use them. Staff managed clinical waste well.

Staff carried out safety checks of specialist equipment. The equipment we checked and had servicing and electrical safety stickers on indicating it was safe to use for the designated purpose. Staff told us they felt the equipment used by them was modern and well maintained. The medical physics department had an annual schedule for medical devices maintenance, service, and audit medical devices in the department. They monitored medical devices that were overdue their service i.e. devices that could not be located or could not be accessed during the yearly visit. When required the department was responsible for following-up with external contractors.

Resuscitation equipment was readily available and easily accessible. The hospital had systems to ensure it was checked regularly, fully stocked, and ready for use.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely.

The service had suitable facilities to meet the needs of the patient's families. There were security systems in place to prevent unauthorised access to some of the areas. It included children's department which was separate from adults waiting areas.

Patients could reach call bells and staff responded quickly when called.

The ED did not provide a therapeutic environment for people with a mental health condition. The two designated psychiatric liaison rooms were located on a busy 'majors' department, and there was no designated space outside of the rooms for people with a mental health condition to use. Staff told us that often there were up to five people with a mental health condition on the ED in one day. This meant that some people with a mental health condition sat on chairs next to the nursing office whilst they waited for the mental health liaison service to assess them. A general ED single occupancy room next to the psychiatric liaison rooms was sometimes used to assess people with a mental health condition when the two designated rooms were occupied. Staff said they removed ligature points from the room to ensure safety.

The two designated psychiatric liaison rooms were used to support people with a mental health condition who presented voluntarily to ED or were brought in under the section 136 of the Mental Health Act (patients brought under section by the police following concerns that they are suffering from a mental disorder). The rooms had one door and contained heavy furniture. The rooms had been carefully considered to minimise risks to patients, such as risks posed by potential ligature anchor points. A ligature point is anything which could be used to attach a cord, rope or other material for the purpose of hanging or strangulation. Each treatment room contained minimal, suitably weighted furniture. Treatments rooms could easily be observed through viewing panels from the corridor and CCTV of the rooms was available in the nursing office. The rooms did not have ensuite facilities. Staff supported patients to use other facilities in the department.

There was a mental health suite located off the ED on the ambulatory care unit. The suite was staffed by the mental health liaison service and used for people who experience mental distress who were deemed to be low risk.

Assessing and responding to patient risk

Staff completed risk assessments for each patient swiftly. They removed or minimised risks and updated the assessments. Staff identified and quickly acted upon patients at risk of deterioration. However, staff were not clear on the trust's rapid tranquilisation policy. Within the first hour post rapid tranquilisation patients had not had any physical health checks recorded.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately.

Staff completed risk assessments for each patient on admission/arrival, using a recognised tool, and reviewed this regularly, including after an incident.

Staff knew about and dealt with any specific risk issues. All nurses completed immediate life support training for both adults and children. Senior nurses completed advanced life support training. Specialist children nurses, in addition, had advanced life support training qualifications. Staff present in the resuscitation area had advance life support qualifications.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about patient's mental health). Staff completed or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide.

ED managers and the mental health liaison service did not monitor when rapid tranquilisation was administered to people with a mental health condition in the ED. Therefore, staff were unable to tell us which patients had received rapid tranquilisation. Staff we spoke to were not clear on the trust's rapid tranquilisation policy.

Patient's care and treatment records we reviewed indicated that when they had been given rapid tranquilisation, they had not had any physical health checks completed within the first hour post rapid tranquilisation. This was not in line with trust policy or NICE guidance which recommends that patients receive regular intermittent physical health checks for a set time period after their medication has been admitted. This presented a risk that staff would not be able to detect potential complications that are more likely to develop immediately after this medication is administered, such as cardiac complications.

Staff shared key information to keep patients safe when handing over their care to others.

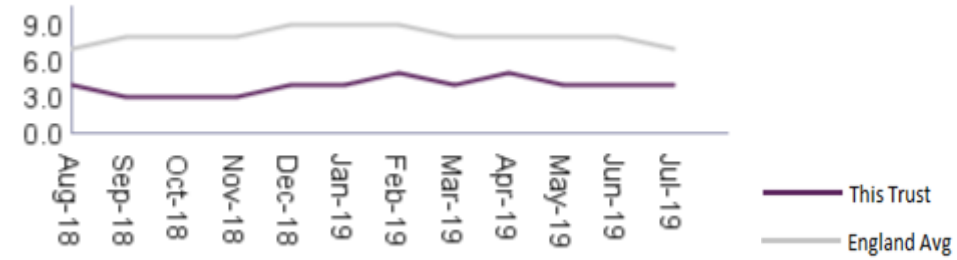
Shift changes and handovers included all necessary key information to keep patients safe.

The trust scored worse than other trusts for one of the five Emergency Department Survey 2018 questions relevant to safety and "about the same" as other trusts for the remaining four questions.

Question	Trust score	RAG
Q5. Once you arrived at A&E, how long did you wait with the ambulance crew before your care was handed over to the emergency department staff?	8.0	About the same as other trusts
Q8. How long did you wait before you first spoke to a nurse or doctor?	6.4	About the same as other trusts
Q9. Sometimes, people will first talk to a doctor or nurse and be examined later. From the time you arrived, how long did you wait before being examined by a doctor or nurse?	6.3	About the same as other trusts
Q33. In your opinion, how clean was the A&E department?	7.9	About the same as other trusts
Q34. While you were in A&E, did you feel threatened by other patients or visitors?	9.1	Worse than other trusts

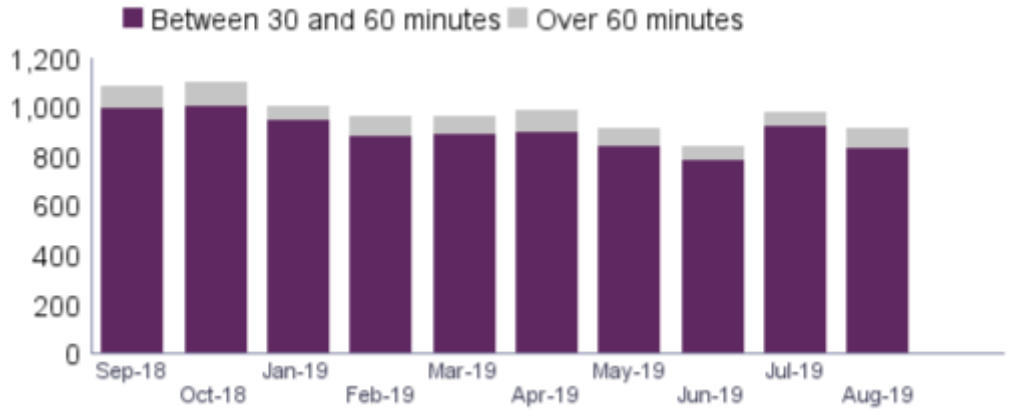
(Source: Emergency Department Survey 2018)

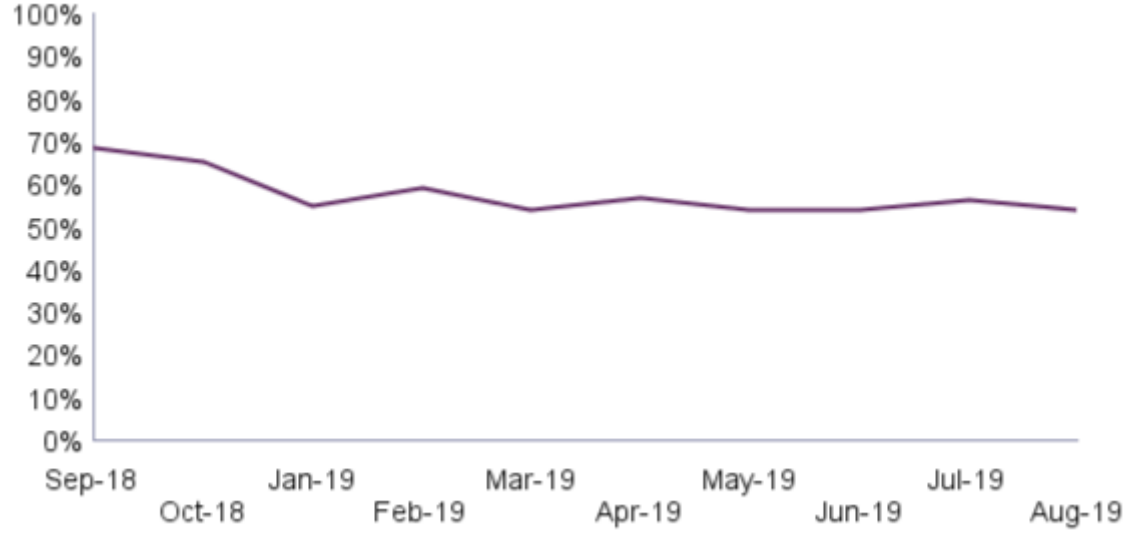
The median time from arrival to initial assessment was better than the overall England median in each month from August 2018 to July 2019. The monthly median ranged from three to five minutes, compared to the England average of between seven and nine minutes.



(Source: NHS Digital - A&E quality indicators)

From September 2018 to August 2019 there was a downward trend in the monthly percentage of ambulance journeys with turnaround times over 30 minutes at Whittington Hospital. The highest percentage of ambulance journey turnaround times over 30 minutes was in September 2018 (68.7%) which reduced to a low of 54.0% in March 2019.



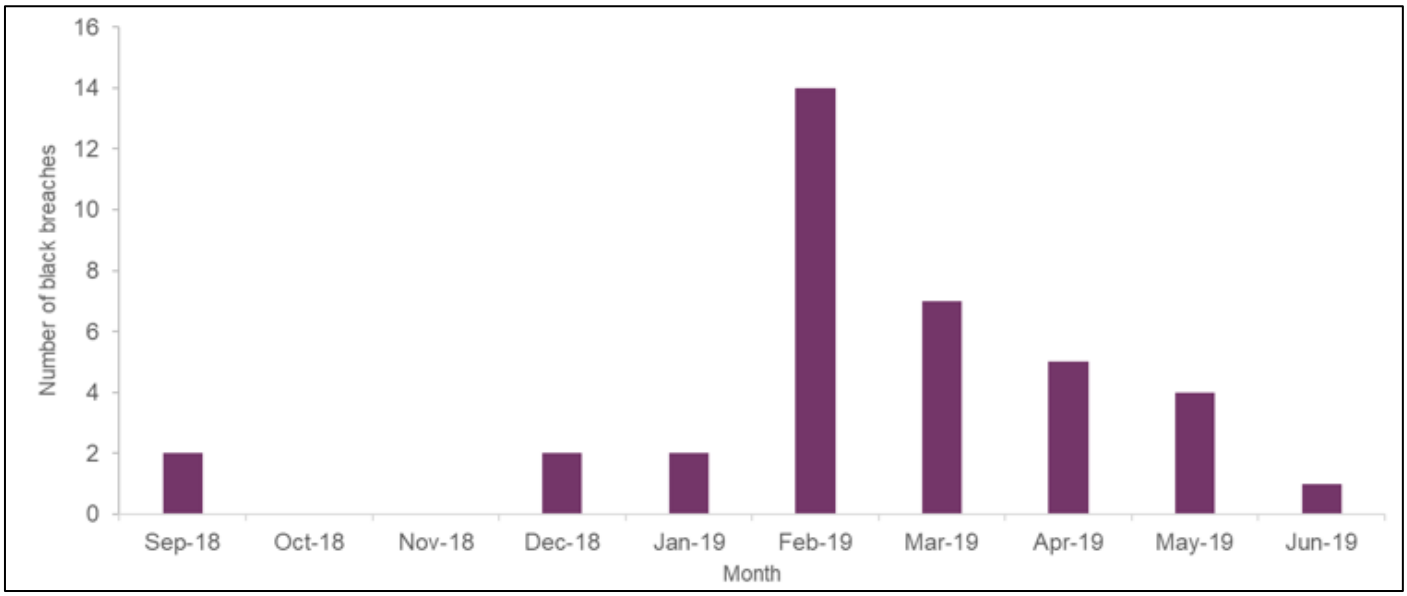


(Source: National Ambulance Information Group)

A “black breach” occurs when a patient waits over an hour from ambulance arrival at the emergency department until they are handed over to the emergency department staff. The trust

only provided data for 10 months as the most recent months' data was not available from the ambulance data portal at the time of reporting.

From September 2018 to June 2019 the trust reported 37 "black breaches". The highest number of black breaches were reported in February 2019, which accounted for 38% of all breaches over the 10-month period. The trust noted that eight of these occurred in one week in February when the emergency department had high numbers of attendances averaging 321 attendances per day and there were additional flow challenges reported across the trust leading to crowding within the department.



(Source: Routine Provider Information Request (RPIR) - Black Breaches tab)

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. However, on occasions, they were unable to fulfil the streaming role with a senior nurse as required by their procedure and were required to use less experienced staff. We did not observe this had a negative impact on patients waiting times and safety.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The table below shows a summary of the nursing staffing metrics in urgent and emergency care at Whittington Hospital compared to the trust's targets, where applicable:

	Urgent and emergency care annual staffing metrics						
	September 2018 to August 2019						
Staff	**Annual**	**Annual**	**Annual**	**Annual**	**Annual**	**Annual**	**Annual**

Group	average establishment	vacancy rate	turnover rate	sickness rate	bank hours (% of available hours)	agency hours (% of available hours)	unfilled hours (% of available hours)
Target		10%	12%	3.5%			
All staff	310.2	20%	7%	18.9%			
Qualified nurses	174.5	13%	6%	21.0%	27,633 (12%)	12,911 (6%)	6,041 (3%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

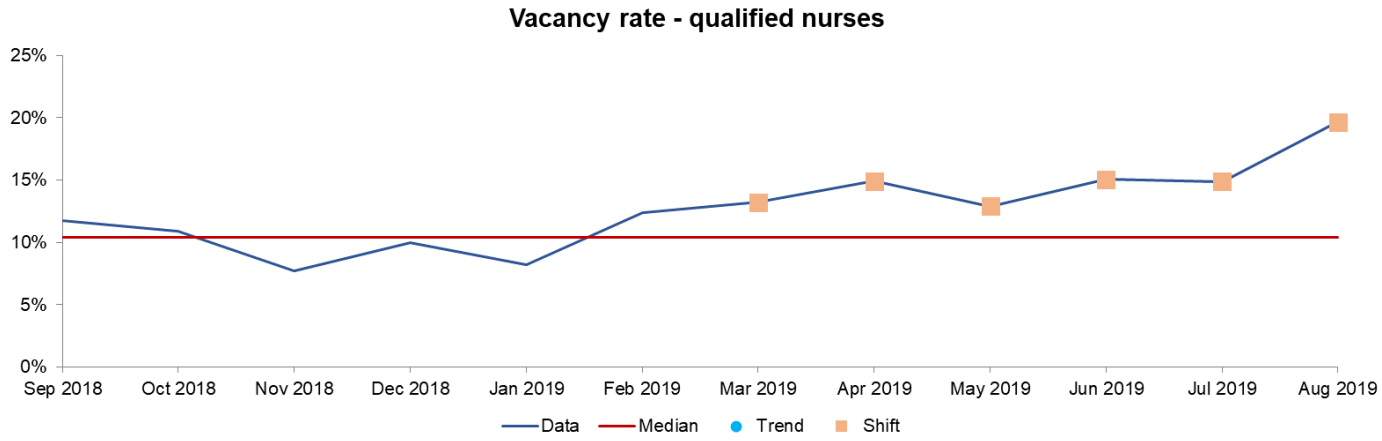
Senior nurses told us that the hospital was able to improve vacancy rates amongst nursing staff. The leaders worked well to improve staff retention by undertaking initiatives aimed at improving staff wellbeing. In 2019 nursing staff establishment had been increased from 15 to 17 whole time equivalent (WTE) in response to undertaken staffing needs analysis and increasing numbers of patients visiting the department each year.

The department manager could adjust staffing levels daily according to the needs of patients.

The number of nurses and healthcare assistants matched the planned numbers.

Nurse staffing rates within urgent and emergency care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly turnover rates.

The service had low and/or reducing vacancy rates.

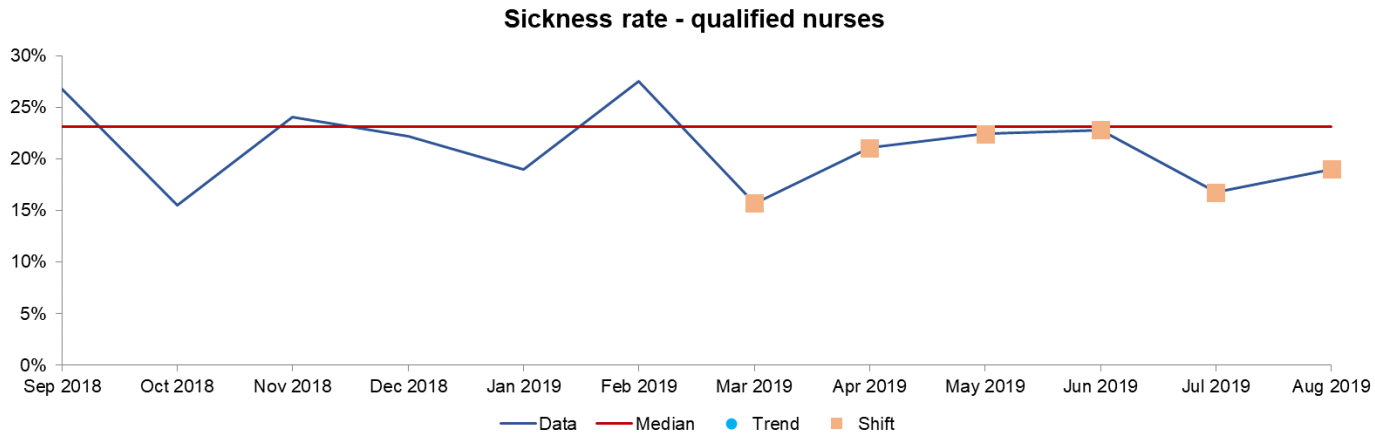


Monthly vacancy rates over the last 12 months for qualified nurses shows a shift from March 2019 to August 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

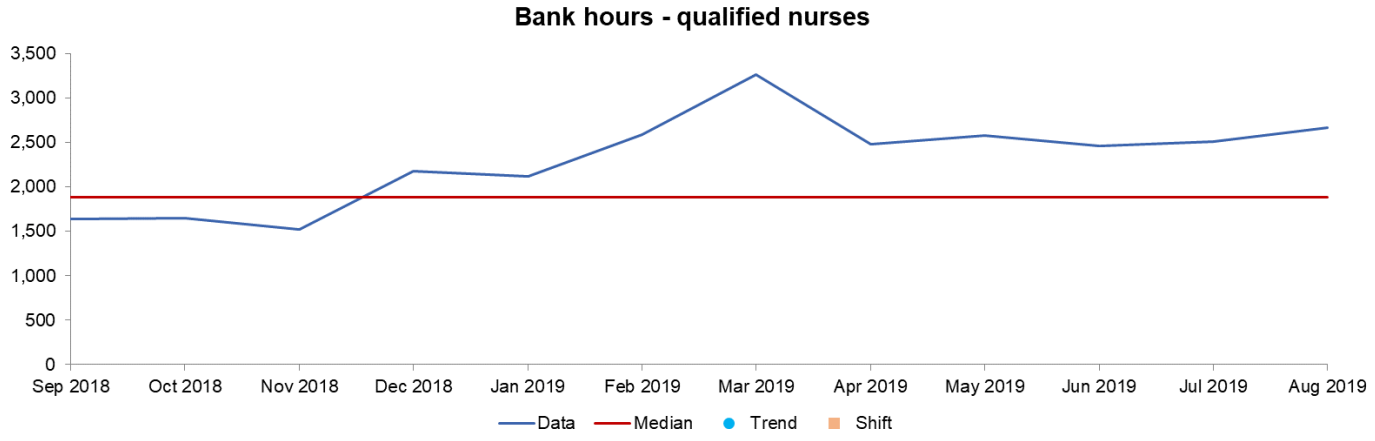
Senior leaders told us that the trust managed to reduce the vacancy rate and overall felt nursing staff were happy to work at the department. They have reviewed and increased nursing staff establishment in 2018 to reflect the changing needs of the department.

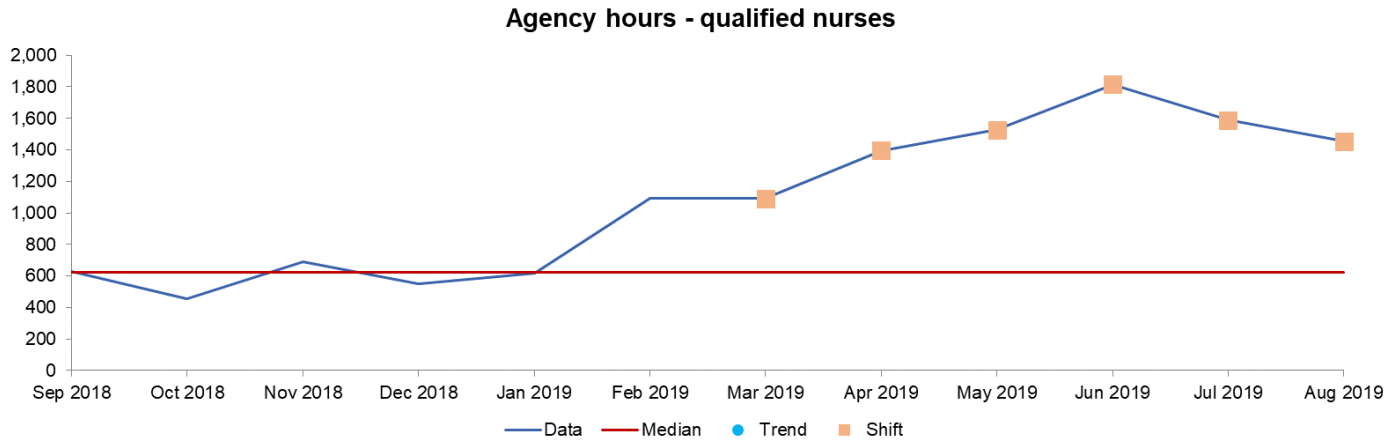
The service had stable sickness rates.



Monthly sickness rates over the last 12 months for qualified nurses shows a shift from March 2019 to August 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)





(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Managers limited their use of bank and agency staff and requested staff who were familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service. Approximately 5% of total nurse shifts were allocated to agency staff within the department. Senior nurses told us that agency staff were well qualified regular staff and all received induction to the trust and the department.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

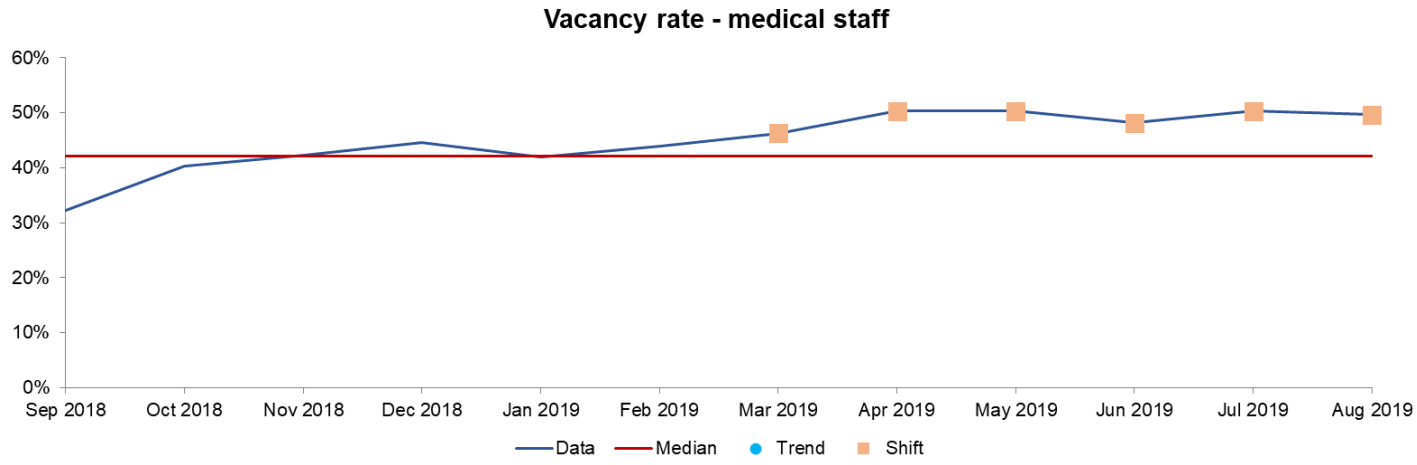
The service had enough medical staff to keep patients safe. There was a consultant cover Monday to Friday 8am to 9pm on-site and on Saturday and Sunday 12pm to 8pm. There were designated on-call rotas that specified who was to provide support for radiology, pharmacy, or who to contact for any specialist medical advice. There were consultants allocated to individual department areas and responsibilities were clearly indicated to all staff. It included a dedicated paediatric ED consultant. The hospital had increased number of consultant posts since our previous inspection.

The table below shows a summary of the medical staffing metrics in urgent and emergency care at Whittington Hospital compared to the trust's targets, where applicable:

	Urgent and emergency care annual staffing metrics						
	September 2018 – August 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	12%	3.5%			
All staff	310.2	20%	7%	18.9%			
Medical staff	43.4	45%	17%	0.0%	16,615 (19%)	8,797 (10%)	2,521 (3%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

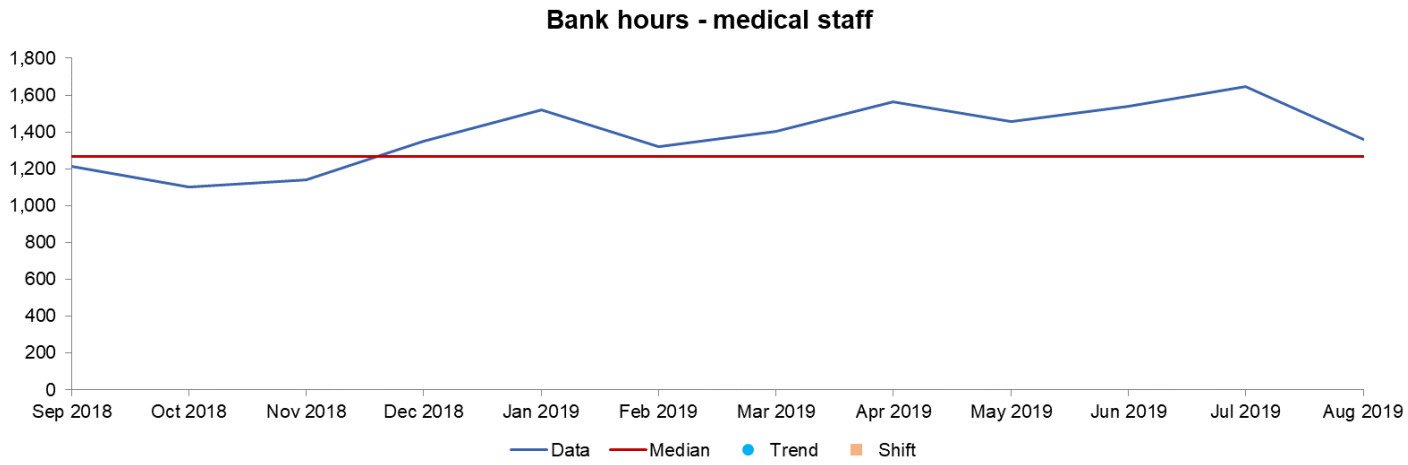
Medical staffing rates within urgent and emergency care were analysed for the past 12 months and there was not sufficient variation in the sickness rates or turnover rates to comment on the performance of these metrics over time.



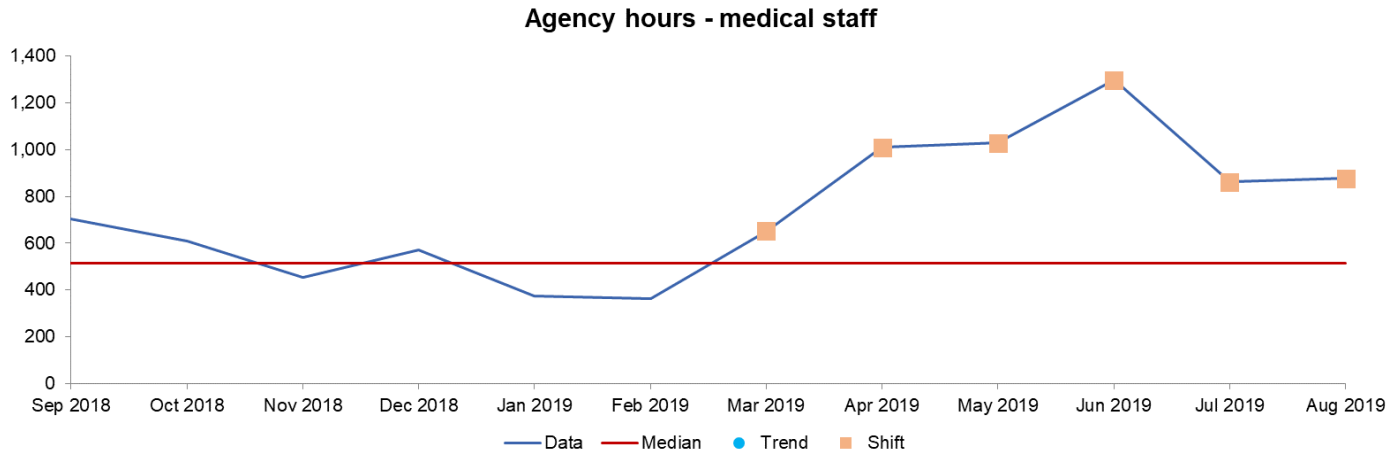
Monthly vacancy rates over the last 12 months for medical staff shows a shift from March 2019 to August 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Senior members of staff told us that there were two vacancies amongst consultants (out of 10 WTE) and the recruitment process was underway at the time of inspection.



Monthly bank hours over the last 12 months for medical staff are not stable and may be subject to ongoing change.



Monthly agency hours over the last 12 months for medical staff shows a shift from March 2019 to August 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum tab)

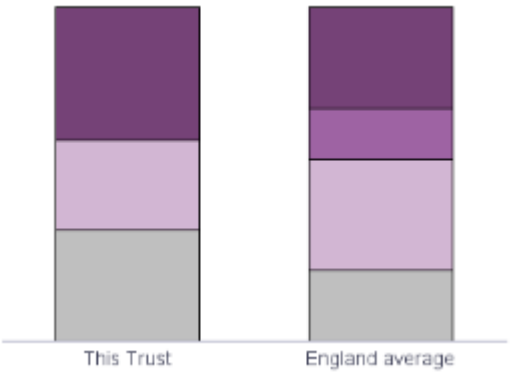
Managers could access locums when they needed additional medical staff.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

In June 2019, the proportion of consultant staff reported to be working at the trust was higher than the England average. The proportion of junior (foundation year 1-2) staff was also higher than the England average.

Staffing skill mix for the 27 whole time equivalent staff working in urgent and emergency care at Whittington Health NHS Trust



	This Trust	England average
Consultant	40%	30%
Middle career^	0%	15%
Registrar group~	27%	33%
Junior*	33%	21%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Records were clear, up-to-date, stored securely and easily available to all staff providing care. Staff kept detailed records of patients' care and treatment in most cases with an exception of observations post administration of rapid tranquilisation when it was administered to patients with a mental health condition.

Staff had access to up-to-date, accurate and comprehensive information on patients' care and treatment. They had access to an electronic records system that they could all update. Patient notes were comprehensive and all staff could access them easily. Clinical staff told us they had access to diagnostic results such as blood results and imaging reports to support them to care safely for their patients.

When patients transferred to a new team, there were no delays in staff accessing their records.

Records were stored securely. Patients medical records reviewed by us in most cases were detailed, patient's allergies were noted, pain assessment record was kept alongside early warning scores and other vital signs checks. Staff also completed pressure ulcers risk assessments when relevant. However, staff did not keep records of observations post administration of rapid tranquilisation when it was administered to patients with poor mental health.

Records of patients' who presented to the emergency department with mental health problems indicated that rapid triage was undertaken and that they received a mental health liaison service assessment within one hour. Mental health liaison service and ED staff had access to both MH trust's records and Whittington Health Trust's computer systems. However, the information entered into the electronic patient's record needed to be repopulated on both systems.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. All controlled drugs (CD) cupboards and registers were checked, and we found no expiry stock discrepancies.

Staff reviewed the patient's medicines regularly and provided specific advice to patients and carers about their medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy.

Staff followed current national practice to check patients had the correct medicines.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines.

Resuscitation trolleys were located at an easily accessible and well-ventilated area, away from radiators. The medicines contained within, consumables, and cylinders were in date and records of expiry dates were also kept in the pharmacy as a backup check.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. They raised concerns and reported incidents and near misses in line with trust/provider policy.

Staff reported serious incidents clearly and in line with trust policy. They felt there was a learning culture and that they could raise issues without worrying about repercussions. The department organised monthly divisional meetings dedicated to learning from deaths. These were attended by a senior nurse and a consultant as well as other nurses and doctors. Staff received feedback from the investigation of incidents, both internal and external to the service. They met to discuss the feedback and look at improvements to patient care. Managers investigated incidents thoroughly. They debriefed and supported staff after any serious incident. Each day Monday to Friday staff met for short meeting dedicated to discussing capacity, incidents and potential patients safety issues ("10 to 10" meeting).

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2018 to September 2019, the trust reported one never event for urgent and emergency care. The never event involved an unintentional connection of a patient requiring oxygen to an air flowmeter. The patient received air instead of oxygen during their resuscitation in

the emergency department. Managers shared learning about the never event with their staff and across the trust.

The department organised monthly mortality and morbidity meetings. Any learning from deaths identified was shared with the wide hospital staff through divisional structures and patents safety committees.

In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in urgent and emergency care which met the reporting criteria set by NHS England from October 2018 to September 2019. This includes the never event described above.

A breakdown of the incident types reported is in the table below:

Incident type	Number of incidents	Percentage of total
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	2	33.3%
Maternity/obstetric incident meeting SI criteria: mother and baby (this include foetus, neonate and infant)	1	16.7%
Surgical/invasive procedure incident meeting SI criteria	1	16.7%
Disruptive/ aggressive/ violent behaviour meeting SI criteria	1	16.7%
Medical equipment/ devices/disposables incident meeting SI criteria	1	16.7%
Total	6	**100.0%**

(Source: Strategic Executive Information System (STEIS))

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, under Regulation 20 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. The service had a policy which described the duty of candour process. Staff we spoke to, understood the duty of candour requirement and its implication to clinical practice. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, patients and visitors.

The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm-free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination. Staff had access to safety thermometer information, which was displayed in the operations room, to inform them of potential pressure points and any incidents.

The department carried out falls audit to identify trends and establish if any mechanism or mitigation were necessary to minimise occurrences (no harm categorised falls).

Records indicated staff assessed patients for risk of falls or risk of developing pressure ulcers.

Data from the patient safety thermometer showed that the trust reported no new pressure ulcers, falls with harm or urinary tract infections in patients with a catheter from August 2018 to August 2019 within urgent and emergency care.

(Source: NHS Digital - Safety Thermometer)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high-quality care according to best practice and national guidance. Staff had access to clinical guidance and could make decisions based on current national guidance.

The department took part in all mandatory audits organised by the Royal College of Emergency Medicine (RCEM) and national quality improvement projects (QIP). It included feverish child, discharging patients after an asthma exacerbation, or national quality improvement project (QIP) on vital signs monitoring in adults. The department also contributed towards 2018-2019 RCEM national quality improvement project (QIP) on venous thromboembolism (VTE) risk management of ambulatory adult ED patients requiring leg immobilisation.

The department carried out internal audits and took action when improvement was identified. It included an audit of inpatient falls, documentation audit, frailty audit, intravenous cannulation audit amongst others. The ED participated in the local trauma network and local peer reviews aimed at identifying good practice and improvements. They organised regular trauma meetings where they discussed risks related to trauma care delivery, staff training needs, or speciality developments in trauma care delivery within the network and national.

Since our previous inspection the service had established a frailty pathway was to improve the care of frail older people moving through the ED, increase their access to comprehensive geriatric assessment and reduce hospital admissions. Staff felt this had improved patients experience with a significant number of admissions avoided.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink.

Staff fully and accurately completed the patient's fluid and nutrition charts where needed.

Specialist support from staff such as dieticians and speech and language therapists was available for patients who needed it.

In the CQC Emergency Department Survey, the trust scored 6.0 for the question "were you able to get suitable food or drinks when you were in A&E?". This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease the pain.

Staff assessed the patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff prescribed, administered and recorded pain relief accurately.

Patients received pain relief soon after requesting it. The department carried out pain relief at triage audits to ensure pain relief was administered promptly and took actions when shortcomings were identified.

In the CQC Emergency Department Survey, the trust scored 7.0 for the question "do you think the hospital staff did everything they could to help control your pain?" This was about the same as other trusts.

(Source: Emergency Department Survey 2018)

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Outcomes for patients were positive, consistent and met expectations, such as national standards.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. They used audit results to improve patient outcomes.

The table below summarises Whittington Hospital's performance in the 2016/17 RCEM moderate and acute severe asthma audit.

The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other Hospitals**	**Met national standard?**
Standard 1a: O2 should be given on arrival to maintain sats 94-98%.	26.3%	Similar	Not met
Standard 2a: Vital signs should be measured and recorded on arrival at the emergency department.	15.8%	Similar	Not met
Standard 3: High dose nebulised β2 agonist bronchodilator should be given within 10 minutes of arrival at the	15.8%	Similar	Not met

emergency department.			
Standard 4: Add nebulised Ipratropium Bromide if there is a poor response to nebulised β2 agonist bronchodilator therapy.	66.7%	Worse	Not met
Standard 5a: If not already given before arrival to the emergency department, steroids given within 60 minutes of arrival (acute severe).	66.7%	Better	Not met
Standard 5b: If not already given before arrival to the emergency department, steroids given within four hours of arrival (moderate).	13.3%	Similar	Not met
Standard 9: Discharged patients should have oral prednisolone prescribed according to guidelines.	0.0%	Worse	Not met

(Source: Royal College of Emergency Medicine)

The table below summarises Whittington Hospital's performance in the 2016/17 RCEM consultant sign-off audit.

The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other Hospitals**	**Met national standard?**
Percentage of patients from high-risk groups reviewed by a consultant in Emergency Medicine prior to discharge from the Emergency Department:			
Atraumatic chest pain in patients aged 30 years and over.	23.1%	Better	Not met
Fever in children under 1 year of age.	0.0%	Worse	Not met
Patients making an unscheduled return to the ED with the same condition within 72 hours of discharge.	0.0%	Worse	Not met
Abdominal pain in patients aged 70 years and over.	4.2%	Similar	Not met

(Source: Royal College of Emergency Medicine)

The table below summarises Whittington Hospital's performance in the 2016/17 RCEM Severe sepsis and septic shock audit.

The audit reports hospital performance in quartiles. In this context, 'similar' means that the hospital's performance fell within the middle 50% of results nationally.

Metrics *(Audit measures)*	Hospital performance	Comparison to other Hospitals	Met national standard?
Standard 1: Respiratory rate, oxygen saturations (SaO2), supplemental oxygen requirement, temperature, blood pressure, heart rate, level of consciousness (AVPU or GCS) and capillary blood glucose recorded on arrival.	96.0%	Better	Not met
Standard 2: Review by a senior (ST4+ or equivalent) ED medic or involvement of Critical Care medic (including the outreach team or equivalent) before leaving the ED.	46.0%	Worse	Not met
Standard 3: O2 was initiated to maintain SaO2>94% (unless there is a documented reason not to):Within one hour of arrival.	52.8%	Similar	Not met
Standard 4: Serum lactate measured: Within one hour of arrival.	46.0%	Similar	Not met
Standard 5: Blood cultures obtained: Within one hour of arrival.	51.0%	Similar	Not met
Standard 6: Fluids – first intravenous crystalloid fluid bolus (up to 30 mL/Kg) given: Within one hour of arrival.	50.0%	Similar	Not met
Standard 7: Antibiotics administered: Within one hour of arrival.	54.0%	Similar	Not met
Standard 8: Urine output measurement/fluid balance chart instituted within four hours of arrival.	29.0%	Similar	Not met

*(*Source*: Royal College of Emergency Medicine)*

The table below summarises Whittington Hospital's performance in the 2018 Trauma Audit and Research Network audit. The TARN audit captures any patient who is admitted to a nonmedical ward or transferred out to another hospital (e.g. for specialist care) whose initial complaint was trauma (including shootings, stabbings, falls, vehicle or sporting accidents, fires or assaults).

Metrics *(Audit measures)*	Hospital performance	Audit Rating	Met national standard?
Case Ascertainment *(Proportion of eligible cases reported to TARN compared against Hospital Episode Statistics data)*	63-75.9%	N/A	Did not meet
Crude median time from arrival to CT scan of the head for patients with traumatic brain injury *(Prompt diagnosis of the severity of traumatic brain injury from a CT scan is critical to allowing appropriate treatment which minimises further brain injury.)*	Not eligible	N/A	N/A

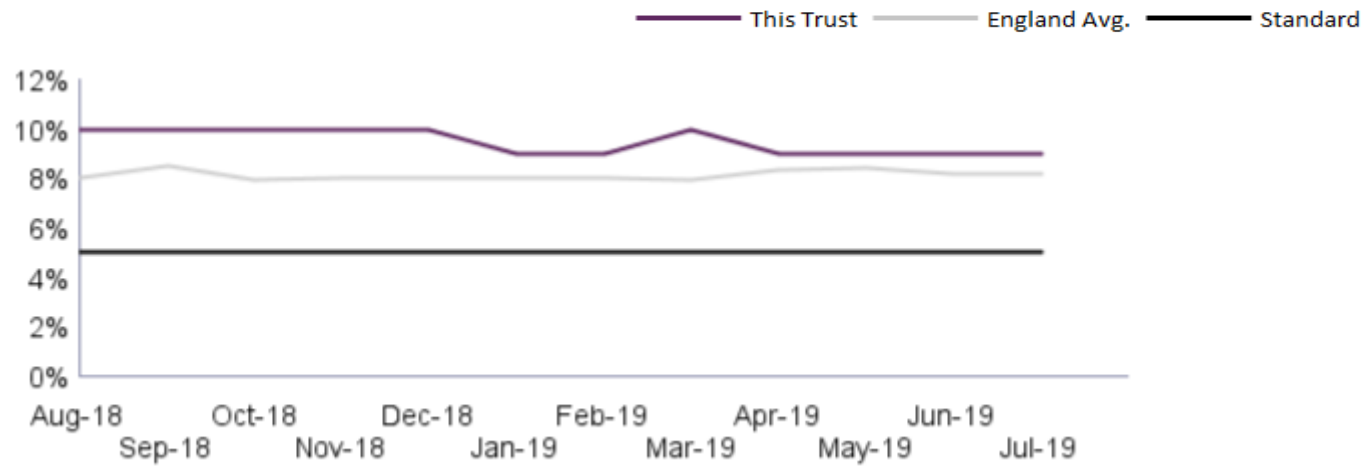
The crude proportion of eligible patients receiving Tranexamic Acid within 3 hours of injury *(Prompt administration of tranexamic acid has been shown to significantly reduce the risk of death when given to trauma patients who are bleeding*)	Not eligible	N/A	N/A
The crude proportion of patients with severe open lower limb fracture receiving appropriately timed urgent and emergency care *(Outcomes for this serious type of injury are optimised when urgent and emergency care is carried out in a timely fashion by appropriately trained specialists.)*	0.0%	Lower than the TARN aggregate	N/A
Risk-adjusted in-hospital survival rate following injury (*This metric uses case-mix adjustment to ensure that hospitals dealing with sicker patients are compared fairly against those with a less complex case mix.*)	2.2 additional survivors	As expected	Met

(Source: TARN)

Managers shared and made sure staff understood information from the audits.

From August 2018 to July 2019, the trust's unplanned re-attendance rate to A&E within seven days was worse than the national standard of 5% and worse than the England average.

Unplanned re-attendance rates at the trust were between 9% and 10% each month compared to the England average of around 8%.



(Source: NHS Digital – A&E quality indicators)

Competent staff

The service made sure staff were competent for their roles. Staff had access to training and development. However, managers have not always appraised staff's work performance regularly.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Managers gave all new staff a full induction tailored to their role before they started work. Managers supported staff to develop through yearly, constructive appraisals of their work.

From October 2018 to September 2019 55.1% of required staff within urgent and emergency care received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	October 2018 to September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Additional professional scientific and technical	1	1	100.0%	90%	Yes
Medical and dental*	18	20	90.0%	90%	Yes
Nursing and midwifery registered	65	113	57.5%	90%	No
Additional clinical services	9	17	52.9%	90%	No
Administrative and clerical	11	25	44.0%	90%	No
Total	**86**	**156**	**55.1%**	**90%**	**No**

* Note that data for medical and dental staff was provided separately by the trust and shows appraisal compliance as at October 2019.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers supported nursing and medical staff to develop through regular, constructive clinical supervision of their work. The clinical educators supported the learning and development needs of staff. Managers made sure staff received any specialist training for their role.

Staff told us they felt they had good training opportunities. Newly trained staff were offered a period when they were guided and supported by qualified practitioners to make the transition from student and to develop their practice further. Staff could participate in the emergency care advanced clinical practitioner programme to enhance their capacity and professional capability. The department organised training in supporting patients with poor mental health, basic orthopaedic plastering techniques, venepuncture (the process of obtaining intravenous access) or intravenous cannulation amongst others. Staff competences were regularly monitored.

Managers made sure all staff attended team meetings or had access to notes when they could not attend. They identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge.

Managers identified poor staff performance promptly and supported staff to improve.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. All staff groups spoke highly of their colleagues and told us they had good working

relationships with their colleagues. We observed good communication and rapport amongst staff taking part in the multidisciplinary meetings.

The department had access to a variety of health professionals to obtain specialist advice or coordinate patient care and treatment should this be necessary. They were well supported by staff working in the ambulatory care unit or those from the frailty team amongst others. Paramedics, working for another NHS trust, told us they appreciated a positive working relationship with the ED department.

Staff worked across health care disciplines and with other agencies when required to care for patients. It included a number of local charities and local authorities responsible for the provision of social care. They referred patients for mental health assessments when they showed signs of mental ill-health, depression. Senior leaders praised medical staff working alongside ED supporting patients on frailty pathway.

Seven-day services

Key services were available seven days a week to support timely patient care.

Patients were reviewed by consultants depending on the care pathway.

There were designated on-call rotas that specified who was to provide support for radiology, pharmacy or other specialist advice out of hours. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Clinical staff had access to the mental health liaison service 24 hours a day and seven days a week. A nurse and on-call doctor provided out of hours support in relation to patients who needed mental health assessment.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support at the department. It contained information related to health promotion, self-care, various medical conditions amongst others.

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle.

The department had a ‘homeless pathway committee’ that met monthly and was working towards improving access to service to patients who did not have a permanent residential address. They coordinated the work with the local social work team and sponsor organisation that aimed to provide access to mobile phones to improve communication between patient and health professionals.

The department cooperated with a charity to improve understanding amongst the ED patients and staff of how social issues affect wellbeing and health and to provide support to young people who are being criminally exploited.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients

who lacked the capacity to make their own decisions or were experiencing mental ill-health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. They gained consent from patients for their care and treatment in line with legislation and guidance.

Staff made sure patients consented to treatment based on all the information available.

For patients under the age of 18, the department could access support from the trust's child and adolescent mental health service (CAMHS) team. Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment.

The trust set a target of 90% for completion of the Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

The trust reported that their safeguarding adults level 1 module provided training covering MCA level 1 and the safeguarding adults level 2 module covers MCA level 2 and DoLS.

A breakdown of compliance for MCA/DOLS training courses as at 31 August 2019 at Whittington Hospital for qualified nursing staff in urgent and emergency care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	122	122	100.0%	90%	Yes
Safeguarding adults level 2	107	122	87.7%	90%	No

In urgent and emergency care the target was met for one of the two MCA/DOLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DOLS training courses as at 31 August 2019 at Whittington Hospital for medical staff in urgent and emergency care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	23	23	100.0%	90%	Yes
Safeguarding adults level 2	13	23	56.5%	90%	No

In urgent and emergency care the target was met for one of the two MCA/DOLS training modules for which medical staff were eligible. Safeguarding adults level 2 training had been completed by 56.5% of staff which equated to ten members of staff not completing the training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on the Mental Capacity Act and Deprivation of Liberty Safeguards.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

The psychiatric liaison rooms were predominantly supervised by healthcare assistants. All patients who attended ED on the section 136 of the Mental Health Act or who were deemed to lack capacity were placed on one to one observation, which was undertaken by healthcare assistants. Healthcare assistants wore red tabards to signal to other ED staff that they were observing people with a mental health condition and they should not be asked to do other duties.

Security staff were used to support patients with mental health needs who displayed physical challenging behaviours in the emergency department. Security staff had been trained in the use of restraint. Security staff filled out a comprehensive incident report each time restraint was used. Training undertaken by security staff included safeguarding, vulnerable adults, conflict management and resolution training which included physical interventions. Security staff felt they would benefit from training related to understanding the needs of patients with mental health needs. ED staff were trained in breakaway technics to allow them to deescalate potential physical interventions.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. Patients felt mostly that they received good service and their experience was positive.

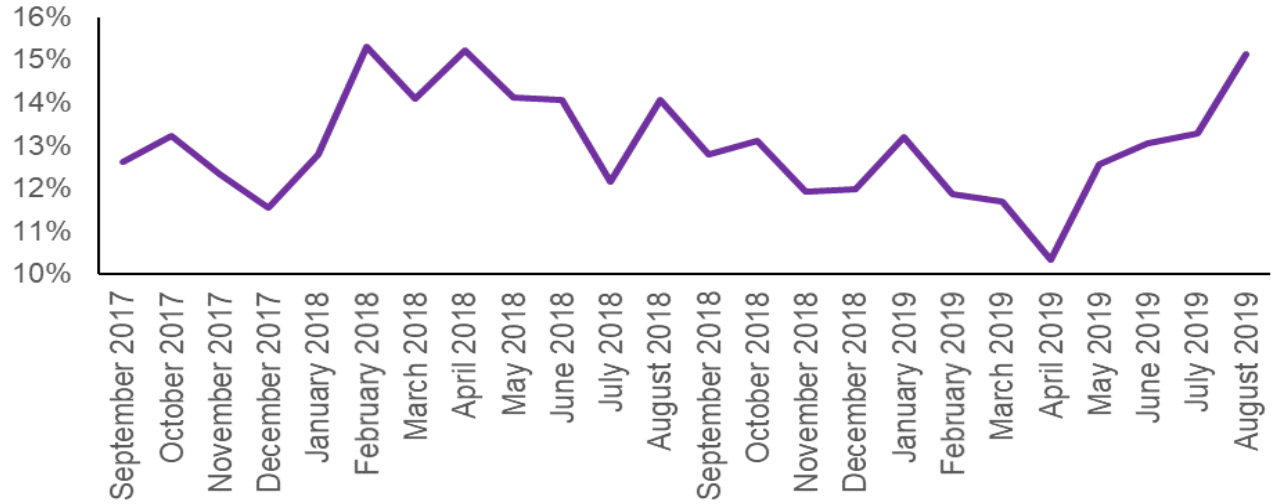
Patients said staff treated them well and with kindness. They said: “staff were polite and friendly”, “kind and caring”, “fantastic service” “they were very helpful” and “they were really on the ball”.

ED staff we spoke with showed understanding and a non-judgmental attitude when talking about patients with mental health needs, learning disabilities, autism or dementia. We spoke with one patient who confirmed staff were non-judgemental and helpful. Staff supported patients who became distressed to help them maintain their privacy and dignity. For example, we saw staff using a privacy divider around the door of one of the mental health assessment rooms when staff were supporting a distressed patient. This protected the privacy and dignity of the patient.

Staff supported patients who became distressed to help them maintain their privacy and dignity.

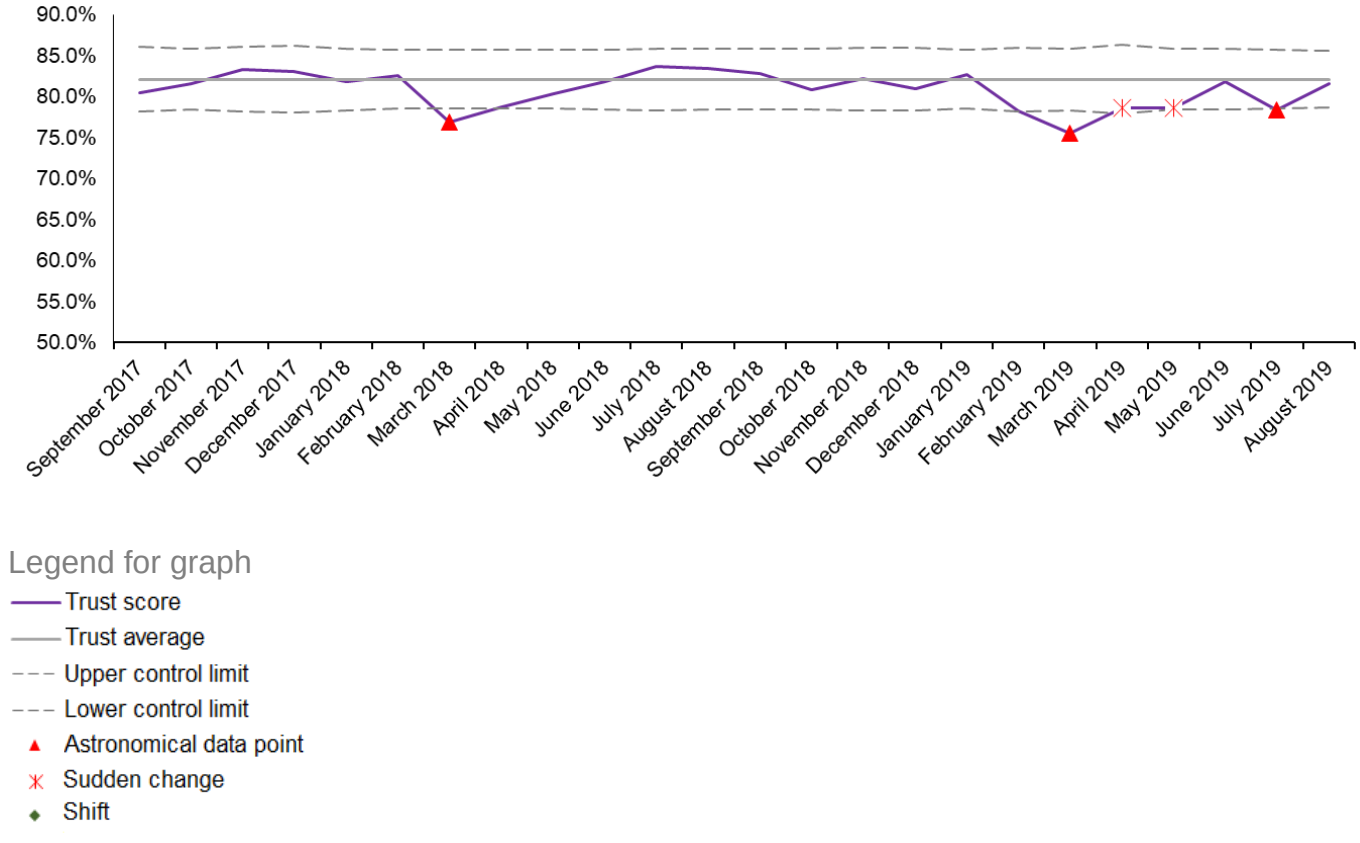
The patient friends and family test asks patients whether they would recommend the services they have used based on their experiences of care and treatment.

Response rates for Whittington Health NHS Trust from September 2017 to August 2019 are shown below.



The chart below shows the mean friends and family test scores, with upper and lower control limits. The width of the control limits are based on the response rates, therefore the higher the response rates (shown by narrower control limits) the more confidence we have in the data.

The trust scored between 75.6% and 83.7% from September 2017 to August 2019.



(Source: Friends and Family Test – NHS England)

Staff followed the policy to keep patient care and treatment confidential.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff were professional, friendly and polite when addressing patients or their relatives. They were willing to help and demonstrated commitment to patient-centred approach.

Patients and a relative we spoke with said they were happy with the support offered and found staff approachable and very responsive.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood the patient's personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff supported patients who became distressed and helped them maintain their privacy and dignity. Staff we spoke with stressed the importance of treating patients as individuals.

We observed that staff spoke to patients compassionately to put them at ease and minimise their distress.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients identified in need of further emotional or psychological support could be referred to their GP or referring doctor for support.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

We observed, and patients told us, that staff were very thorough and answered all patients' questions patiently and in a considerate manner. We observed good rapport between staff and patients and staff displayed good listening skills. Patients told us that "doctors were really good and explained everything" and that "the staff were brilliant" and "good at keeping [patients] informed".

Staff made sure patients and those close to them understood their care and treatment. Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Patients gave positive feedback about the service. Staff could give examples of how they used patient feedback to improve the quality of care they provided. For example, they have redecorated the relatives room in response to feedback provided by patients.

The trust scored about the same as other trusts for all of the 26 Emergency Department Survey questions relevant to the caring domain.

Question	Trust score	RAG
Q10. Were you informed how long you would have to wait to be examined?	4.3	About the same as other trusts
Q11. While you were waiting, were you able to get help from a member of staff to ask a question?	6.9	About the same as other trusts
Q13. Did you have enough time to discuss your condition with the doctor or nurse?	8.4	About the same as other trusts
Q14. While you were in A&E, did a doctor or nurse explain your condition and treatment in a way you could understand?	8.0	About the same as other trusts
Q15. Did the doctors and nurses listen to what you had to say?	8.7	About the same as other trusts
Q17. Did you have confidence and trust in the doctors and nurses examining and treating you?	8.7	About the same as other trusts
Q18. Did doctors or nurses talk to each other about you as if you weren't there?	8.6	About the same as other trusts
Q20. If a family member, friend or carer wanted to talk to a doctor, did they have enough opportunity to do so?	7.6	About the same as other trusts
Q21. While you were in A&E, how much information about your condition or treatment was given to you?	8.7	About the same as other trusts
Q23. If you needed attention, were you able to get a member of medical or nursing staff to help you?	7.1	About the same as other trusts
Q24. Sometimes, a member of staff will say one thing and another will say something quite different. Did this happen to you?	8.6	About the same as other trusts
Q25. Were you involved as much as you wanted to be in decisions about your care and treatment?	7.4	About the same as other trusts
Q45. Overall, did you feel you were treated with respect and dignity while you were in A&E?	8.7	About the same as other trusts
Q16. If you had any anxieties or fears about your condition or treatment, did a doctor or nurse discuss them with you?	7.1	About the same as other trusts
Q27. Did a member of staff explain why you needed these test(s) in a way you could understand?	8.4	About the same as other trusts

Question	Trust score	RAG
Q28. Before you left A&E, did you get the results of your tests?	7.6	About the same as other trusts
Q29. Did a member of staff explain the results of the tests in a way you could understand?	8.9	About the same as other trusts
Q30. If you did not get the results of the tests when you were in A&E, did a member of staff explain how you would receive them?	4.5	About the same as other trusts
Q38. Did a member of staff explain the purpose of the medications you were to take at home in a way you could understand?	9.0	About the same as other trusts
Q39. Did a member of staff tell you about medication side effects to watch out for?	4.8	About the same as other trusts
Q40. Did a member of staff tell you when you could resume your usual activities, such as when to go back to work or drive a car?	5.5	About the same as other trusts
Q41. Did hospital staff take your family or home situation into account when you were leaving A&E?	4.6	About the same as other trusts
Q42. Did a member of staff tell you about what symptoms to watch for regarding your illness or treatment after you went home?	6.4	About the same as other trusts
Q43. Did hospital staff tell you who to contact if you were worried about your condition or treatment after you left A&E?	7.1	About the same as other trusts
Q44. Did staff give you enough information to help you care for your condition at home?	7.0	About the same as other trusts
Q46. Overall... (please circle a number)	7.7	About the same as other trusts

(Source: Emergency Department Survey 2018)

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

From July 2018 to June 2019 there were 109,365 attendances at the trust's urgent and emergency care services. The percentage of A&E attendances at this trust that resulted in an admission

remained similar in 2018/19 when compared to 2017/18 (16%). In both years, the proportions were lower than the England average (19%).

The resuscitation area, for the most seriously ill or injured patients, had four bays in total; three bays for adults and one for children. Next to it, there was the majors area for people with serious injuries or illnesses that are not immediately life-threatening. It had 15 beds including isolation rooms and two rooms designated for people living with mental health conditions.

Patients who came to the ED, other than by ambulance, went to the waiting room and had an initial assessment (triage). The triage was provided by an emergency nurse practitioner to both non-priority ambulance patients as well as those in the waiting area. Following the initial assessment, patients were sent either to the majors' area, could see a GP based on site (service provided by another provider) or went to the urgent care centre.

There was a designated emergency medicine unit (EMU), equipped with 12 recliner chairs where patients could await diagnostic tests results or undergo additional observations. The ambulatory care unit was located next door to the ED and provided hospital care during the day for people who did not need to be admitted.

Although, facilities and premises were appropriate for the services being delivered they were in need of redecorating. We observed that walls had been damaged in numerous areas, many of the seats in the waiting areas were broken with their tops being removed. Although we did not observe patients standing, staff told us on occasions there might not be sufficient seating available if the department was very busy. The overall appearance of the department did not give the impression of being friendly and welcoming.

The waiting room was equipped with a screen that provided patients with up to date information related to approximate waiting times. The department also used patient-friendly signs for treatment pathway indication. It guided patients at each stage of their pathway through the department according to which department there were allocated. It helped to manage patient's expectations in relation to waiting times and explain why some patients were being seen quicker than others.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health problems, learning disabilities and dementia.

Managers planned and organised services, so they met the changing needs of the local population. The service had systems to help care for patients in need of additional support or specialist intervention.

The service relieved pressure on other departments through utilisation of the ambulatory care service or an observation area where patients could spend up to eight hours to undergo additional monitoring when necessary.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet their needs.

We heard examples of reasonable adjustments being made to the treatment environment for a patient with a learning disability and noted responsive and carrying treatment being provided. The

staff ensured patients were prioritised and discussed their individual needs with the patient and their relatives or carers and acted accordingly. Staff were aware of the learning disability liaison nurse based at the hospital and told us they would contact them should they need any specific support.

The department was accessible to patients with mobility difficulties with access to toilet and lower reception desk which could be used by those using a wheelchair to mobilise.

Staff had access to communication aids to help patients become partners in their care and treatment. Patients, relatives and carers could get help from interpreters or signers when needed.

The trust scored about the same as other trusts for all of the three Emergency Department Survey 2018 questions relevant to the responsive domain.

Question – Responsive	**Trust score**	**RAG**
Q7. Were you given enough privacy when discussing your condition with the receptionist?	7.2	About the same as other trusts
Q12. Overall, how long did your visit to A&E last?	7.3	About the same as other trusts
Q22. Were you given enough privacy when being examined or treated?	8.9	About the same as other trusts

(Source: Emergency Department Survey 2018)

Access and flow

People could access the service when they needed it and received the right care promptly.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets. Although the hospital did not operate a formal streaming procedure due to an insufficient number of senior staff to fulfil the role. Patients told us, and we observed, that they spent on average 15 minutes waiting (from their arrival at the department) before they were seen by a nurse. The department aimed to allocate a senior nurse to stream patients arriving in the ED but were on occasions unable to do so and were required to use less experienced staff.

Patients could access a GP service located on-site operated by another provider (day and night-time).

Since our previous inspection, the department had reconfigured the clinical decision unit into emergency medicine unit (EMU) and replaced 10 beds with 12 recliner chairs which were to be used for up to 8 hours for patients who did not need inpatient admission but required additional test or observations. Staff felt that this has improved patients experienced as it helped to manage the flow within the department better. Some patients arriving by ambulance could go directly to the EMU bypassing the majors. Staff felt that it helped to prevent readmissions and helped with managing pressures on hospital inpatients beds. However, at the time of the inspection there was one patient who stayed within the EMU for over 48 hours (hospital bed was provided) and was not admitted to regular hospital inpatient bed due to limited hospital’s capacity. Staff followed the escalation procedure and the decision to allow for the prolonged stay of the patient was taken by the hospital's senior leader as per protocol set out.

Staff had a good awareness of beds availability within the hospital as they received reports six times a day and participated in the bed management meeting organised twice a day by the site management.

The service had arrangements, known to all staff we spoke with, to meet patients' urgent or emergency mental health care needs, including outside office hours and in an emergency. Staff completed parallel assessments when patients had both physical and mental health needs. This meant that patients received the care and support they needed quicker.

Where patients required admission to a mental health hospital staff reported that there were delays in accessing beds and support from mental health professionals.

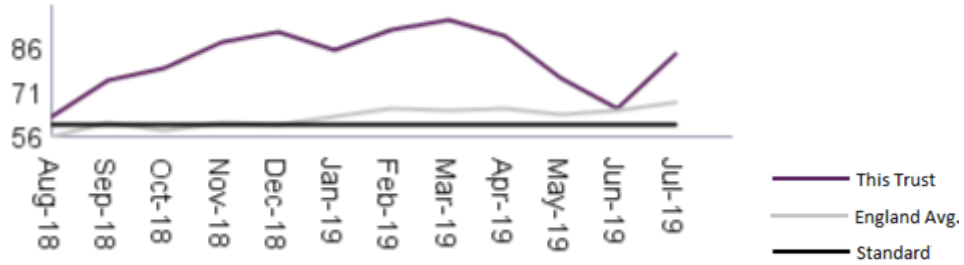
Most of the patients' who presented to the emergency department with mental health condition received a mental health assessment within one hour, in line with the one-hour target monitored by the trust. ED staff told us that the mental health liaison service team in general responded to referrals very promptly. However, the managers of the department did not ensure that the service agreement, which they had with the mental health liaison service, was sufficiently monitored to ensure compliance with the trust's target was set at 95% patients being assessed within one hour.

Percentage ED patients seen by mental health liaison service within one hour of referral presented in the table below.

April 2019	May 2019	June 2019	July 2019	Aug 2019	Sept 2019
95%	94%	96%	91%	89%	84%

The Royal College of Emergency Medicine recommends that the time patients should wait from time of arrival to receiving treatment should be no more than one hour. The trust did not meet this standard in any of the 12 months from August 2018 to July 2019.

Performance against this standard showed a deteriorating trend from August 2018 to March 2019. From April 2019 performance improved to in line with the England average by June 2019.

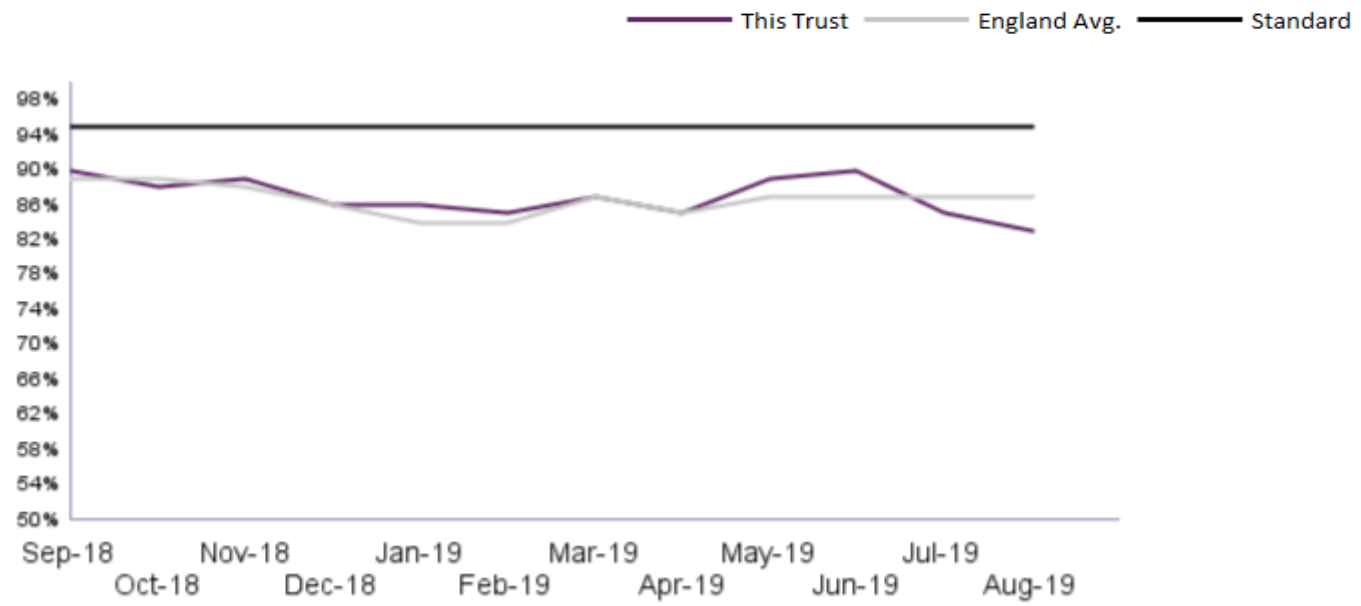


(Source: NHS Digital - A&E quality indicators)

Managers and staff worked to make sure patients did not stay longer than they needed to.

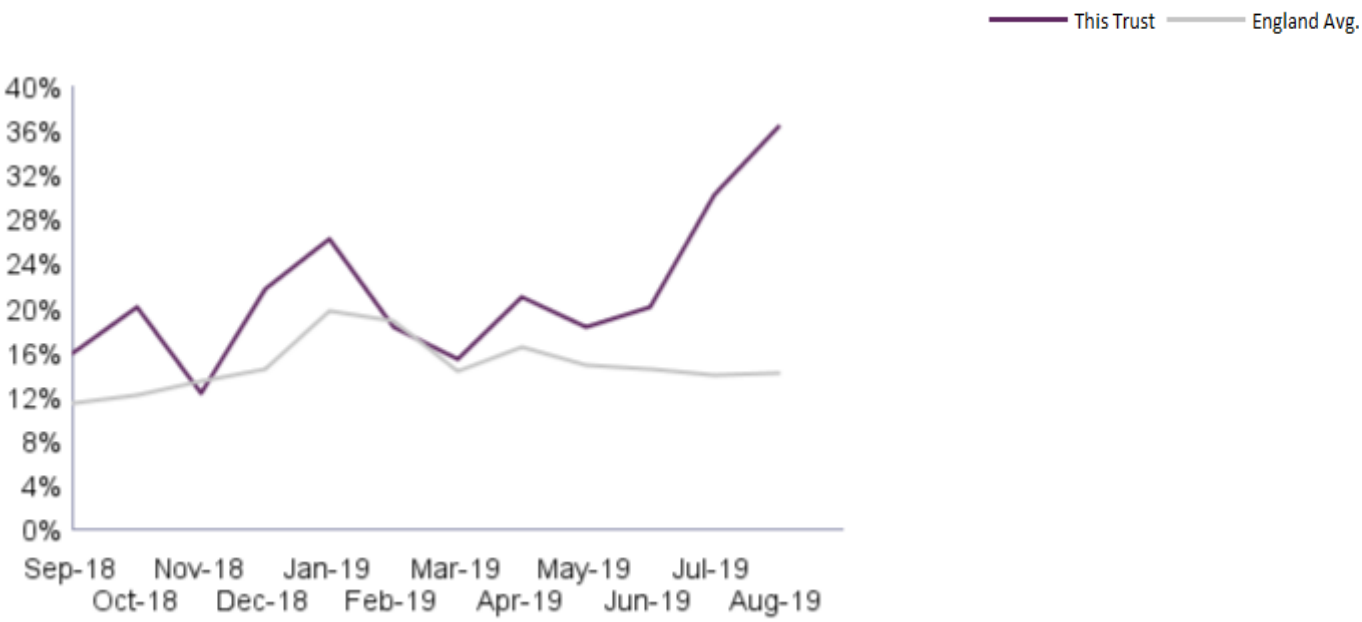
The Department of Health's standard for emergency departments is that 95% of patients should be admitted, transferred or discharged within four hours of arrival in the emergency department.

From September 2018 to August 2019 the trust failed to meet the standard. Performance against this metric remained generally similar to the England average until June 2019. From this point, there was a trend of deterioration with performance below the England average in July 2019 and August 2019. The lowest performance was in the most recent month with 83% of patients being admitted, transferred or discharged within four hours.



(Source: NHS England - A&E Waiting times)

From September 2018 to August 2019 the trust's monthly percentage of patients waiting more than four hours from the decision to admit until being admitted was generally worse than the England average. The longest waits were reported in the most recent two months (July 2019 and August 2019).



(Source: NHS England - A&E SitReps).

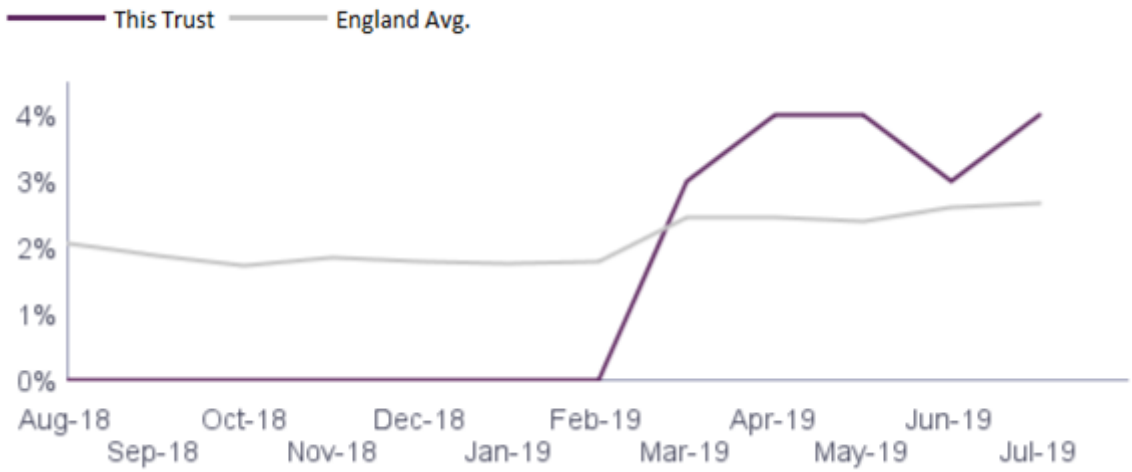
Over the 12 months from September 2018 to August 2019, 32 patients waited more than 12 hours from the decision to admit until being admitted. The highest numbers of patients waiting over 12 hours were in the most recent three months: June 2019 (seven), July 2019 (12) and August 2019 (10).

Month	Number of patients waiting more than four hours to admission	Number of patients waiting more than 12 hours to admission
Sep-18	222	0
Oct-18	280	0
Nov-18	187	0
Dec-18	326	1
Jan-19	386	0
Feb-19	239	1
Mar-19	229	0
Apr-19	297	1
May-19	266	0
Jun-19	273	7
Jul-19	391	12
Aug-19	448	10

(Source: NHS England - A&E Waiting times)

The monthly percentage of patients that left the trust's urgent and emergency care services before being seen for treatment was better than the England average from August 2018 to February 2019 and worse than the England average from March 2019 to July 2019.

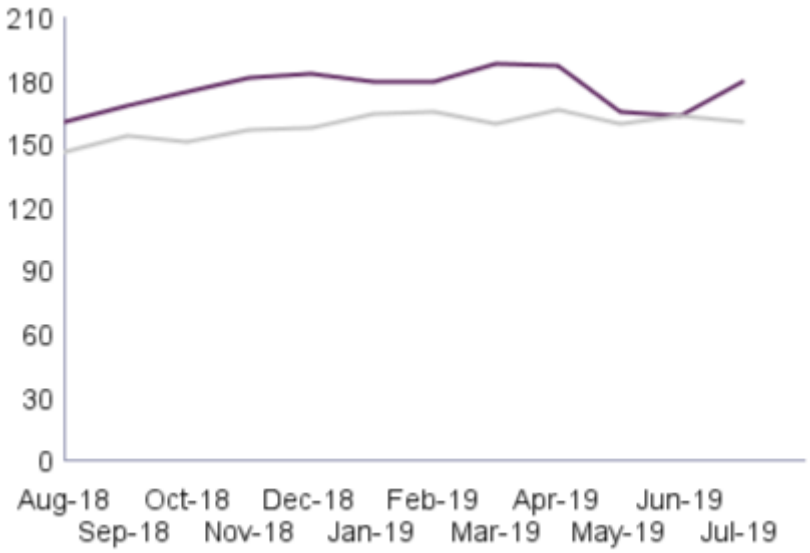
From September 2018 to February 2019 no patients left the department without being seen for treatment but performance in this metric deteriorated from March 2019 to July 2019 with between 3% and 4% of patients leaving the department without being seen.



(Source: NHS Digital - A&E quality indicators)

From August 2018 to July 2019 the trust's monthly median total time in A&E for all patients was higher than the England average from August 2018 to February and similar to the England average form March 2019 to June 2019.

From August 2018 to July 2019 performance against this metric ranged from 161 minutes to 187 minutes compared to the England average of between 146 minutes and 166 minutes.



(Source: NHS Digital - A&E quality indicators)

Staff supported patients when they were referred or transferred between services or hospital departments.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about the care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Patients, relatives and carers knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas. Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes.

From August 2018 to July 2019 the trust received 53 complaints in relation to urgent and emergency care at Whittington Hospital (16.4% of total complaints received by the trust). The trust took an average of 27.5 days to investigate and close complaints. This was not in line with their complaints policy, which states non-complex complaints should be closed within 25 days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Other	15	28.3%
Missed diagnosis	10	18.9%
Poor treatment provided	6	11.3%
Rudeness/disrespectful	4	7.5%
Discharge - inadequate support (i.e. care package)	2	3.8%
Inadequate communication about treatment (options poorly explained)	2	3.8%
Inadequate monitoring provided	2	3.8%
Inadequate treatment provided	2	3.8%
Inconsiderate/uncaring/dismissive	2	3.8%

Incorrect information in medical records	2	3.8%
Lack of information to patient	2	3.8%
No treatment provided	2	3.8%
Poor verbal communication - inaccurate	2	3.8%
Total	**53**	**100.0%**

The category ‘other’ has been used where only one complaint was recorded under a category. The trust used a large number of categories to report complaints, with similar themes not grouped together. This approach could make it difficult for the trust to monitor and act upon the themes of complaints over time.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Senior nurses were involved in investigating complaints and drafting formal responses when required.

Managers shared feedback from complaints with staff and learning was used to improve the service.

From August 2018 to July 2019 there were 59 compliments about urgent and emergency care at the trust (16.2% of total compliments received by the trust).

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The local leadership team were experienced and demonstrated a good understanding of the performance challenges and risks within the emergency department. Senior members of staff we spoke with had been in post for several years and had a very good knowledge of the hospital and its systems and processes.

Staff told us local managers were “caring”. They also said that all matrons were very approachable, visible and supportive. They also said that hospital’s leaders were visible including the chief executive officer or chief operating officer amongst others.

The staff we spoke with did not share with us any negative comments about their senior or local management teams.

The department focused on enabling and empowering all staff to be leaders in their own right. Staff within the department had access to the trust’s in-house ‘ICARE’ values-based leadership programme.

Vision and strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action,

developed with all relevant stakeholders.

Although the department did not have formalised long-term strategy leaders said that consultations were in progress in relation to the redevelopment of the department.

Staff knew well the trust vision which was to “help local people live longer, healthier lives” and the trust’s strategic goals.

The department’s fabric was in need of refurbishment and staff said it feels that it is no longer able to accommodate the number of people visiting the department. The department observed continuous annual increases of patients, but they were limited by the space they could utilise to accommodate them. Although the trust’s estates strategy was focused on other priorities, there was a plan to work with a mental health service provider to develop mental health unit on site which aimed to support co-ordination of services for patients with both physical and mental health needs and potentially reduce pressures within the ED related attendance of patients with poor mental health.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service monitored staff culture through a staff survey. Staff told us they felt teamwork was "excellent" and there was a “good team spirit”. Various teams and staff groups worked together to improve patients experience. Staff told us they felt “valued” by their local leaders and the trust overall.

Leaders told us they wanted to ensure an open and inclusive culture at all levels, one in which staff communicated well, worked together and cared for each other.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The department was managed within the emergency and medicine integrated clinical service unit (ICSU). This ICSU had been reconfigured since our previous inspection when emergency and medicine were managed within different divisions. The staff we spoke to felt the divisional structure worked well and help them to develop a closer and more effective working relationship with medical specialities within the hospital.

The department organised monthly meetings dedicated to quality improvements and safeguarding high standards within the department. It included patients’ safety meetings, patients’ experience meetings and ICSU’s board meeting.

Staff felt they could influence cost improvement plans that affected the department and felt involved in decisions taken that affected the department.

The trust had a service level agreement with the local mental health trust for provision of mental health liaison. There were monthly partnership meetings involving ED managers and the mental health liaison team to look at issues such as related to clinical governance.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The service had a local risk register which was updated regularly. The risks highlighted on the risk register were current and control measures had been put in place to minimise it with regular updates provided. There were leads allocated to each of the item placed on the risk register responsible for overseeing mitigation actions. The top risk were formally shared with the ICSU board who were to approve any changes to risk ratings will. The staff we spoke to were not concerned of any immediate risks that would impact day to day operation of the department.

The department had regular departmental meetings, such as daily ‘10 to 10’ meeting dedicated to discussing capacity, incidents and potential patients’ safety issues, as well as other decision making and performance monitoring forums such as senior management meetings and divisional level meetings.

The department encouraged and welcomed feedback related to performance and quality of the care and treatment provided. For example, in 2018, the trust completed an independent review following a number of serious incidents relating to people with mental health condition attending ED.

Information management

The service collected reliable data and analysed it. The staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were secure.

Staff had access to up-to-date, accurate and comprehensive information on patients’ care and treatment. All staff had required access to record systems to allow them to perform their work effectively.

We were not made aware of any data security breaches that occurred at the ED department within the past 12 months prior to the inspection.

Access to individual patient's records was restricted to authorised staff who had varied access rights and editing privileges granted in accordance with their job role. Patient's records were stored in line with personal data security standards and entries made in the patient's records could be easily ascertained attributed to the person creating them.

The department used information available through performance reports and local audits to inform and improve service planning. This was easily available and easy to understand for staff involved in care and treatment delivery. The information was also timely and relevant.

Engagement

Leaders and staff actively and openly engaged with patients, staff, the public and local organisations to plan and manage services. They collaborated with partner organisations

to help improve services for patients.

Staff told us they felt engaged in the day to day operation of the department and could influence changes. They had regular staff meetings which they used to share information related to complaints or incidents, for learning and sharing examples of good practice and to provide support to one another. Staff said they felt listened to when they made suggestions related to service delivery improvement. The department undertook a number of wellbeing initiatives such as "team days away", “tea at three” or “take a break” initiatives which aimed to raise awareness of the importance of staff taking regular breaks at work and encouraged staff to talk about concerns.

The department engaged patients by encouraging them to take part in a patient’s survey such as friends and family test (FFT). The FFT response rate demonstrated stable increase since April 2019 and was at around 15%. Results of the survey and comments made by patients were discussed at staff meetings and informed planned improvements.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. Leaders encouraged innovation and participation in research.

The department supported ‘not dying alone’ project which involved volunteers visiting the department twice a week. They actively engaged local partners and charities to improve patients outcomes and provide a holistic approach to their care and treatment needs. For example, they worked with a charity that provided support to older people, especially those who have dementia. They had close links with a charity that could offer help to adults with multiple and complex needs and support for vulnerable young people who are being criminally exploited.

The department undertook number of staff wellbeing initiatives and recognised importance of maintaining positive staffing culture in the ED environment and its impact on delivery of care and treatment. It included "team days away", “tea at three” or “take a break” initiatives which aimed to raise awareness of the importance of staff taking regular breaks at work and encouraged staff to talk about concerns.

Surgery

Facts and data about this service

The trust has six main operating theatres covering services including breast surgery, bariatric surgery, colorectal surgery and laparoscopic procedures for colorectal surgery, day case cholecystectomy and hernia repair. It also has four theatres dedicated to day surgery. The trust has three surgical wards and a day treatment centre.

Day surgery procedures are undertaken for most specialities, other than have ophthalmology, ENT and plastics patients who were seen as outpatients only. Dermatology is provided in an outpatient environment. The orthopaedics and trauma department provides day case and emergency services as well as elective care. Daily trauma lists are held for emergency patients. There is also a growing spinal service. The trust provides cancer surgery for some breast, colorectal, gynaecology and urology patients. However, complex cases would be referred to one of the cancer centres at other NHS trusts within London.

(Source: Routine Provider Information Request (RPIR) – Sites tab)

The trust had 7,528 surgical admissions from March 2018 to February 2019. Emergency admissions accounted for 2,584 (34.3%), 3,591 (47.7%) were day case, and the remaining 1,353 (18.0%) were elective.

(Source: Hospital Episode Statistics)

We inspected the surgical services as part of an announced inspection (they did know we were coming) between 3 and 5 December 2019. As part of our inspection, we visited three surgical wards, three theatres and recovery suites, the pre-assessment unit and the Day Treatment Centre (DTC).

As part of our inspection we reviewed information provided by the trust about staffing, training and monitoring of performance.

During our inspection we spoke with 42 members of surgical staff of all grades including nursing staff, surgeons, anaesthetists, health care assistants, operating department practitioners, matrons, physiotherapists, occupational therapists, house keepers, the flow liaison office, the enhanced recovery lead nurse, the stoma lead nurse and the triumvirate managers.

We looked at 11 sets of patient records and spoke with 20 patients and three relatives.

We also observed two ward handover meetings, a ward board round, a theatre briefing meeting and theatre observations.

We followed a patient journey from theatre admission area to theatre and recovery. We also observed multiple interactions between staff and patients.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or

discriminatory abuse.

Mandatory training

Mandatory training compliance was below the trust target.

Mandatory training completion rates

Not all nursing staff received and kept up-to-date with their mandatory training. The trust set a target of 90% for completion of mandatory training.

The table below shows most of the training modules did not meet the trust target for nursing staff. We carried out checks on training compliance with the surgery department on site and confirmed most staff were not compliant with mandatory training. However, theatre staff reported mandatory training was 95 percent completed.

A breakdown of compliance for mandatory training courses as at 31 August 2019 at Whittington Hospital for qualified nursing staff in surgery is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Fire safety	110	115	95.7%	90%	Yes
Health and safety	108	115	93.9%	90%	Yes
Infection prevention and control	107	115	93.0%	90%	Yes
Risk management / duty of candour	104	115	90.4%	90%	Yes
Resuscitation	102	115	88.7%	90%	No
Equality and diversity	99	115	86.1%	90%	No
Conflict resolution	95	115	82.6%	90%	No
Moving and handling	94	115	81.7%	90%	No
Information governance	92	115	80.0%	90%	No

In surgery the 90% target was met for four of the nine mandatory training modules for which qualified nursing staff were eligible.

Not all medical staff received and kept up-to-date with their mandatory training.

The table below shows none of the training modules met the trust target for medical staff. We carried out checks on training compliance with the surgery department on site and confirmed staff had not completed required training.

A breakdown of compliance for mandatory training courses as at 31 August 2019 at Whittington Hospital for medical staff in surgery is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Resuscitation	84	117	71.8%	90%	No

Risk management / duty of candour	73	117	62.4%	90%	No
Fire safety	62	117	53.0%	90%	No
Information governance	60	117	51.3%	90%	No
Equality and diversity	56	117	47.9%	90%	No
Health and safety	55	117	47.0%	90%	No
Infection prevention and control	54	117	46.2%	90%	No
Moving and handling	39	117	33.3%	90%	No
Conflict resolution	30	117	25.6%	90%	No

In surgery the 90% target was met for none of the nine mandatory training modules for which medical staff were eligible. In five of the training modules less than 50% of medical staff had completed the required training. The lowest training completion was 26% for conflict resolution.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Updated mandatory training figures for medical staff were not available to view at the time of our inspection. Mandatory training covered a range of topics, this included role specific topics for each staff member. In addition to the training modules in the table above, mandatory training also included sepsis management, safeguarding, mental capacity act (MCA) and deprivation of liberty safeguards (DoLS). Staff we spoke with confirmed they received effective training which comprised both online and face-to-face training in safety and safeguarding systems, processes and practices to meet patient needs. However, data provided by the trust demonstrated training compliance was poor and training rates fell below the trust target.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia. Staff we spoke with reported they received training on supporting patients with mental health needs, learning disabilities, autism and dementia as part of their mandatory training. Staff told us how they appropriately recognised and responded to patients whilst adapting their care to suit the patient needs. For example, staff ensured communication suited the patient, and helped them understand their care and treatment and details of their care and treatment. Staff received support from the safeguarding lead and the mental health lead to further support patients when required.

Managers monitored mandatory training and alerted staff when they needed to update their training. Surgical staff across nursing, allied health professional and medical teams accessed their own mandatory training record on the trust's electronic staff record system. The system informed staff of their completed training and upcoming renewal dates. Staff we spoke with reported they were up-to-date with their mandatory training and received email alerts when any training was due to remind them. Managers reported they booked staff onto face-to-face training, then informed and reminded staff of the training date.

The surgical monthly Ward Clinical Quality Indicators report included the latest nursing mandatory training compliance figures for October 2019. We saw the report displayed on one ward. The table below shows nursing staff compliance for all three surgical wards over a three-month period from the monthly Ward Clinical Quality Indicators report.

Ward/Dept	July 2019	September 2019	October 2019
Coyle	76%	71%	70.4 %
Mercers	73%	75%	78.3%

Thorogood	76%	76.4%	79.1%

Mandatory training figures for wards show minimal improvement over the past few months and a deterioration for Coyle ward. The November dashboard was not available at time of our inspection. We spoke with the matron who reported mandatory training compliance was static and identified challenges affecting compliance rates (for example, releasing staff from patient care to complete their training). However, to improve compliance, the Coyle supernumerary ward manager had started to take over patient care to release staff for short periods to complete training.

Another challenge identified was the limited access staff had to face to face sessions. We were informed there had been some timing issues with the education team regarding planning and syncing with the rota planning. This had been escalated and planning face to face training sessions was in the process of review.

To increase training figures, staff we spoke with confirmed they could access training from home, once completed, staff were given their time back. There were also two additional facilities where staff could access on line training, one off site facility, where staff were available to support if needed and the trust social club also had some computer terminals available.

Safeguarding

Staff mostly understood how to protect patients from abuse and the service worked well with other agencies to do so. However, not all staff had completed safeguarding training on how to recognise and report abuse.

Safeguarding training completion rates

The trust set a target of 90% for completion of safeguarding training.

Not all nursing staff received training specific for their role on how to recognise and report abuse. Safeguarding training was part of nursing staff mandatory training, however not all staff completed their safeguarding training.

A breakdown of compliance for safeguarding training courses as at 31 August 2019 at Whittington Hospital for qualified nursing staff in surgery is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	115	115	100.0%	90%	Yes
Safeguarding children level 1	2	2	100.0%	90%	Yes
Safeguarding adults level 2	99	113	87.6%	90%	No
Safeguarding children level 2	92	110	83.6%	90%	No
Safeguarding children level 3	2	3	66.7%	90%	No

In surgery the 90% target was met for two of the five safeguarding training modules for which qualified nursing staff were eligible. Safeguarding children level 3 module was completed by 66.7% staff but only three staff were eligible for this module.

Not all medical staff received training specific for their role on how to recognise and report abuse. Safeguarding training was part of medical staff mandatory training, however not all staff completed their safeguarding training.

A breakdown of compliance for safeguarding training courses as at 31 August 2019 at Whittington Hospital for medical staff in surgery is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	117	117	100.0%	90%	Yes
Safeguarding adults level 2	53	117	45.3%	90%	No
Safeguarding children level 2	44	117	37.6%	90%	No

In surgery the 90% target was met for one of the three safeguarding training modules for which medical staff were eligible. Less than 50% of staff had completed safeguarding adults level 2 and safeguarding children level 2.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. Staff received training on supporting patients with specific needs or characteristics including mental health conditions, learning disability, autism, substance misuse, and dementia. This enabled staff to appropriately protect patients. Staff told us how they adapted care to meet their needs and kept confidentiality to protect patients.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. A trust wide policy for safeguarding adults and children was available to all staff through the trust intranet. Staff we spoke with were aware of the safeguarding policy and the process to follow to protect people at risk of or suffering significant harm. The service appropriately shared information internally with multidisciplinary teams such as the safeguarding team, the mental health lead, occupational therapy (OT) and physiotherapy (PT). Information was also shared with other agencies such as general practitioners (GPs), care homes and community services to support, help and protect people.

Arrangements were in place to enable patients to remain safe when assessed to be at risk of suicide or self-harm. Staff reported they had appropriate access to the trust mental health liaison team for advice and guidance. Staff felt they had the right support to best care for patients whilst waiting for a mental health assessment, following a referral.

It was noted the mandatory training programme did not include Female Genital Mutilation (FGM) either within safeguarding training or stand alone. There was a lead Midwife for FGM case support.

The service had provisions to safeguard women or children with, or at risk of, Female Genital Mutilation (FGM), as the trust had an FGM lead. However, most staff had little awareness or understanding of FGM and did not know the process to follow to report FGM cases. Staff we spoke with also did not confirm FGM training was provided as part of mandatory training.

However, following our inspection the trust reported they had actioned bespoke FGM training to be arranged for surgery staff, in collaboration with maternity services. The training was planned to be completed by the end of January 2020.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff we spoke with were aware of the safeguarding process to follow, which included escalating any concerns to a nurse in charge and making a safeguarding referral. Staff were aware of the trust safeguarding lead and felt confident to approach them for further support or guidance if required. Contact details for the safeguarding lead were displayed around the surgical services. The service had safeguarding systems, processes and practices in place to keep people safe, which were communicated to staff and appropriately implemented.

Staff followed safe procedures for children visiting the ward. Although the surgical services had separate paediatric pathways, the safeguarding training covered both adults and children for child visitors. Children were always accompanied by an adult who had responsibility for the child when visiting relatives.

Cleanliness, infection control and hygiene

The surgical services did not always control infection risk well. Staff did not consistently use control measures to protect patients, themselves and others from infection. Whilst we saw examples of good practice on the wards and in theatres, staff in recovery areas did not always practice good hand hygiene. In addition, staff did not consistently follow processes to record that equipment was clean and ready for use. Cleaning records were not always kept up to date and we saw some items of equipment which were dusty.

Cleaning records were not consistently up-to-date to demonstrate that all areas were cleaned regularly. For example, the requirement to carry out daily cleaning tasks in the anaesthesia room, prior to start of anaesthesia in the morning and or in the afternoon, was not consistently met. Records contained in the purple folders located in each anaesthesia room, displayed gaps and therefore absence of evidence resulting in poor compliance for daily cleaning checks. We also found resuscitation trolleys on surgical wards were not cleaned as documented. For example, dust was apparent on the top of all three trollies, one on each ward.

Whilst we observed staff on the wards used handwashing facilities and hand sanitising gel when caring for patients and moving between clinical areas in accordance with national standards. During an hour observation whilst in the recovery room however, several staff did not wash their hands or use the provided hand sanitizer gel, even when delivering patients from theatre and transferring patients out. We prompted two members of staff and neither followed the infection control principle of hand hygiene. The trust completed hand hygiene audits which showed December 19 hand hygiene compliance in theatres was 93.8 percent.

Although staff cleaned equipment after patient contact, we did not consistently see equipment labelled to show when it was last cleaned, for example the use of ‘I am clean’ stickers were not always evident on equipment not in use.

However, staff accessed infection prevention and control policies and procedures on the trust’s intranet. Staff followed guidance on being bare below the elbows and not wearing jewellery such as jewelled rings and watches. Staff followed infection control principles including the use of personal protective equipment (PPE). PPE including gloves and aprons were available across all

surgical areas, including wards, outside bays and side rooms. We observed staff using PPE appropriately and in line with protocol.

During preoperative assessments staff screened patients using comprehensive questionnaires for a range of potential infection risks. The service used swabs to screen all patients for methicillin-resistant staphylococcus aureus (MRSA). Methicillin-susceptible Staphylococcus aureus (MSSA) and contact with infections such as tuberculosis (TB) influenza (Flu) and clostridium difficile (C. diff) were screened through the questionnaire and referred to infection control if swabs were required.

The service generally performed well for cleanliness. All ward areas were clean and had suitable furnishings which were clean and well maintained. We saw the October nursing clinical quality indicators dashboard for surgical services, which reported wards were 100 percent compliance in hand hygiene. Patients we spoke with confirmed areas were always of a desired cleanliness, and they observed staff washing their hands and wearing gloves and aprons. Staff worked together to keep the theatres and wards clean and free of clutter. We saw equipment and dirty laundry were stored away from corridors and patient areas.

Staff worked effectively to prevent, identify and treat surgical site infections. Staff we spoke with reported they worked closely with the infection control team. They communicated any concerns and received advice and guidance on how to prevent and identify infections.

Staff used records to identify how well the service prevented infections. Staff appropriately sterilised equipment to prevent the risk of infections. The surgical dashboard displayed details of prevented infections including, MRSA, MSSA and C.diff.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well. However, staff did not always carry out daily safety checks of specialist equipment.

Patients could reach call bells and staff responded quickly when called. Patients we spoke with confirmed staff answered call bells in a timely manner. Patients reported they had no concerns for staff response even during busier periods they felt staff were very attentive.

The design of the environment followed national guidance. The surgical theatres and wards environment and equipment were fit for purpose. The pre-assessment area appeared compact and there was not a separate clinic area for weighing patients, which meant patient's weight measurements were taken in the corridor. However, patients we spoke with did not report this as a concern, and felt their privacy and dignity was respected.

Staff did not always carry out daily safety checks of specialist equipment. Resuscitation trolleys and anaesthetic equipment we examined was available and fit for purpose, however it was not always checked in line with professional guidance. The service did not meet the guidelines of the Association of Anaesthetists of Great Britain and Ireland (AAGBI) for daily checks of essential clinical equipment in theatres such as the Anaesthesia Machines. The guideline states this task must be signed for daily and prior to the start of a theatre list. We looked at log books in three surgical theatres and found there were several gaps and blank dates with no signatures.

For daily checks of the defibrillator on the emergency resuscitation trolley prior to start of patient procedure, we found no signature recorded on 3 December 19 and 4 December 19 in the Day Treatment Centre (DTC).

We looked at the resuscitation trolleys on the surgical wards, and found documented checks were completed, however, we found Intravenous (IV) fluid was out of date and blood culture bottles in the sepsis bags were out of date. We reported this at the time of our inspection and these were replaced immediately.

The service had suitable facilities to meet the needs of patient's families. The waiting area and consultation rooms in the pre-assessment department were suitable to meet the needs of patients' families. There was adequate space to allow relatives to attend the consultation with their family member. On the surgical wards in the bays and in the side rooms there was also adequate space for relatives attending the wards.

The service had enough suitable equipment to help them to safely care for patients. Staff reported they had good access to equipment. Instruments, equipment and implants were in compliance with the Medicines and Healthcare products Regulatory Agency (MHRA) requirements. Medical physics managed the database for medical equipment and were responsible for the servicing and Portable Appliance Testing (PAT). Theatres and surgical wards were tidy and well equipped. Most equipment we looked at had been cleaned and tested for electrical safety. We saw staff had labelled equipment to show when it required servicing. Equipment we checked was in date for servicing.

Equipment used for bariatric services were safe and appropriate for people. For example, the facility followed good practice guidance to provide one to one care for patients. The surgical wards facilitated a High Dependency Unit (HDU) to care for bariatric patients.

Staff disposed of clinical waste safely. Across surgical areas clinical waste was managed effectively and collected regularly by porters who removed it to the correct place to prevent any build up.

Assessing and responding to patient risk

Staff mostly completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff could access patient notes quickly in case any change to their medical condition occurred. Nursing staff provided immediate care for deteriorating patients and requested urgent support from a senior nurse or immediate input from a doctor. Staff told us there was always someone senior around for to support them.

Staff in pre-assessment informed us if a patient was identified as at risk of deterioration they transferred them to the Emergency Department (ED) where they passed on all their relevant details and received updates of their care. The pre-assessment department also referred high risk patients identified from the preoperative questionnaire to the anaesthesia clinic which ran twice weekly.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. They kept clear records and accessed support as and when required. Staff carried out robust pre-assessment screening questionnaires of patients. This was documented in an assessment form on the electronic system which included patient medical history, questions about medication and exercise tolerance. At pre-assessment staff completed checks of patient's blood pressure, urine, heart rate and tested for infections.

Staff also asked patients about social needs after surgery to help the service to plan the patient's discharge from hospital.

On surgical wards staff completed risk assessments and documented them on the online system, staff had access to a technical device which gave a real time update of assessments. For example, these included the malnutrition universal screening tool (MUST), body map and pressure ulcer risk (Waterlow), falls risk and mental capacity.

Nursing staff used the National Early Warning Score (NEWS), to record routine physiological observations such as blood pressure, temperature and heart rate. Early warning scores enabled early recognition of a patient deterioration by grading the observations and prompting nursing or medical reviews at specific trigger points. We reviewed six patient records and saw the NEWS assessment had been appropriately carried out with escalation when required.

As part of the quality and improvement projects the service implemented the use of a continuous respiratory monitor to detect patient deterioration on a small cohort of post-laparotomy patients on Mercers ward over a six-month period, from August 2019. Staff recognised the respiratory rate was an early indicator of deterioration in a patient however, it was very poorly observed and documented. The device was attached to a patient and continuously monitors their respiratory rate. The rate was shown on a simple monitor at the nurses station or the device itself can be set to alarm. If the patient's respiratory rate moved outside set parameters the device alerted the clinical staff.

In the surgical theatres we observed staff used the World Health Organisation (WHO) surgical safety checklist. The WHO is a simple checklist developed by the World Health Organisation, which reduces surgical risk through a series of checks on the patient's identity, operation site, procedure and consent. It also included identification and dedicated role of all staff present. We followed a patient through theatre and noted all checks were completed appropriately.

The service had systems in place to ensure staff identified and treated sepsis within an hour as recommended by the sepsis six guidelines developed by the UK Sepsis Trust. The trust had a protocol for sepsis recognition and treatment. There was a sepsis policy and guidance available for staff on the trust intranet, we reviewed this, and found guidance was in date with good version control and signposts to changes. There was also a two-page adult sepsis pathway document available on line which included a RAG rated format with clear identified actions, antimicrobial therapy guidance and guidelines in the use of prophylaxis antimicrobials in surgery.

As recommended by NHS England, the service had developed local safety standards for invasive procedures (LocSSIPs). The standards set out the key steps necessary to deliver safe care for patients undergoing invasive procedures. For example, the service developed an Interventional Radiographer LocSSIPs, which included sections on 'before the procedure', 'time out' and 'sign out'.

Staff knew about and dealt with any specific risk issues. For example, one ward manager reported the increase in patient falls and, to mitigate the risk, introduced twice weekly checks on care bundles, discussed concerns with the falls link nurse, and ensured patients had the appropriate slipper socks on. Around the wards we also saw equipment close to patient beds, including chairs and walkers, that had red posters labelled 'high risk of falls' to inform staff, patients and relatives.

The surgical wards and pre-assessment departments had regular huddles where specific risks and issues were discussed and shared to inform all staff. Staff knew who to escalate any concerns to and were supported by senior staff once they identified them.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). The surgical team contacted the mental health liaison team for support for patients who were feeling stressed, unhappy, depressed, sad, worried or anxious. Staff we spoke with felt they had an appropriate awareness of caring for patients with mental health concerns.

Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. Staff were aware of the mental health lead and reported they could access them for support and advice when required. Staff felt they had appropriate training which provided them with awareness and understanding to support patients with mental health concerns.

Staff shared key information to keep patients safe when handing over their care to others. Sharing of appropriate information was evident throughout our inspection. When handing over care between nursing staff and medical staff information was appropriately shared to keep patients safe.

Shift changes and handovers included all necessary key information to keep patients safe. We observed two handovers on surgical wards and one surgical theatre briefing and found the surgical handover process was very thorough. All were patient centred and included appropriate multidisciplinary discussions of relevant patient information.

Whilst risk assessments were completed we found the service did not consistently follow guidance for the monitoring of patient temperatures in the intraoperative and postoperative recovery phase. For example, patient records in theatres demonstrated patient temperatures were not measured and documented before induction of anaesthesia and then 30 minutes until end of surgery. However, we reviewed eight patient records on wards and found patient temperatures were measured and documented in patient records.

We also found consultant led ward rounds were not completed daily across all wards. For example, on Coyle ward records showed consultants completed 48-hour ward rounds. However, following our inspection the trust planned to review consultant job plans for all specialties on and using the surgical wards to ensure consultant led daily ward rounds.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

The table below shows a summary of the nursing staffing metrics in surgery at Whittington Hospital compared to the trust's targets, where applicable:

	Surgery annual staffing metrics						
	September 2018 to August 2019						
Staff Group	**Annual average**	**Annual vacancy**	**Annual turnover**	**Annual sickness**	**Annual bank**	**Annual agency**	**Annual unfilled**

	establishment	rate	rate	rate	hours (% of available hours)	hours (% of available hours)	hours (% of available hours)
Target		10%	12%	3.5%			
All staff	473.6	15%	10%	12.8%			
Qualified nurses	228.4	22%	10%	16.8%	47,381 (16%)	20,443 (7%)	4,854 (2%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

The ward manager could adjust staffing levels daily according to the needs of patients. Staff were rotated between wards Coyle and Thorogood, they shared a ward manager who adjusted the staffing levels when required.

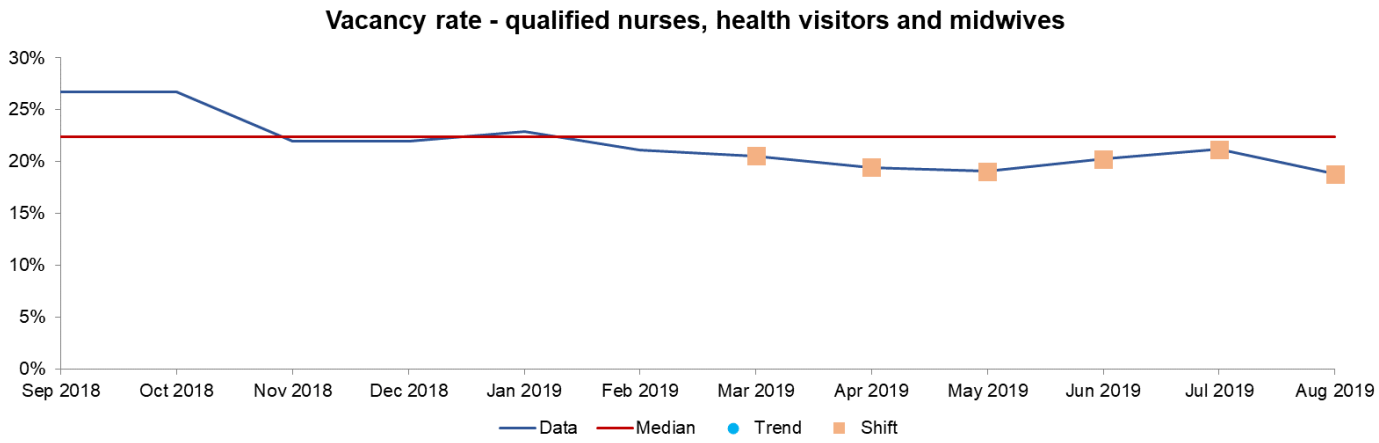
The number of nurses and healthcare assistants mostly matched the planned numbers. For example, we reviewed the staffing levels on two wards and found the actual numbers generally met the planned levels. The figures were displayed on the wards for staff and patients to view.

Nurse staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover, sickness and bank use.

During our inspection managers reported staffing levels had increased. Managers we spoke with reported they stated this was due to the recruitment of overseas staff. The ward manager reported staffing levels on Coyle ward for the previous year was 50 percent vacancies, and they were proud they filled the positions.

Vacancy rates

The service had reducing vacancy rates.



Monthly vacancy rates over the last 12 months for qualified nurses shows a shift from March 2019 to August 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

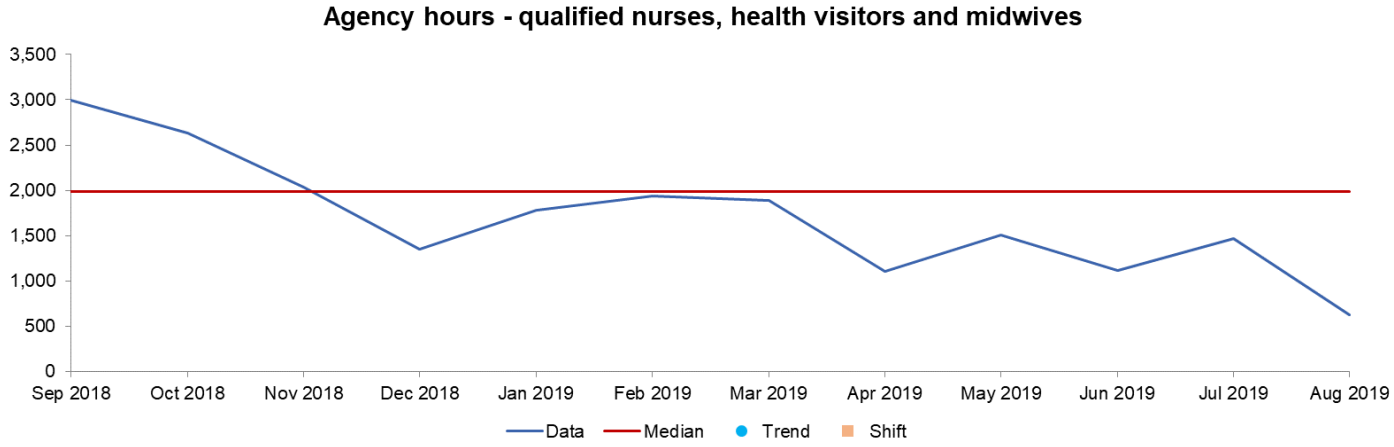
The service had reducing turnover rates. Managers we spoke with reported they looked for development opportunities and areas for progression when recruiting staff to improve the turnover rates.

Sickness rates

The service had reducing sickness rates. From the nursing clinical quality indicators report for August to October 2019 there was evidence of a reducing sickness rate. For example, on Coyle Ward September results showed 5.4 percent sickness rates with October reducing to 1.7 percent. Managers we spoke with confirmed they were working with human resources, who supported with staff performance and sickness. Managers were working to improve the sickness rates.

Bank and agency staff usage

The service had reducing rates of bank and agency nurses. Staff we spoke with confirmed the service did not use bank or agency staff. This was supported with the recruitment of overseas staff.



Monthly agency hours over the last 12 months for qualified nurses are not stable and may be subject to ongoing change.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

Managers limited their use of bank and agency staff and requested staff familiar with the service. Managers reported the reduction of bank and agency staff across surgery services. According to the nursing clinical quality indicators for October 2019 on Mercers and Thorogood wards no agency staff were used.

Managers made sure all bank and agency staff had a full induction and understood the service. All staff received an induction for the service which included role specific information.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. However, we were not assured patients were reviewed daily by consultants on all wards, from records we reviewed on Coyle Ward, the consultant ward round was every 48 hours not daily as recommended. Following our inspection however, the trust reported they were to review consultant job plans for all specialties on and using the surgical wards to ensure seven-day cover for consultant led ward rounds is delivered.

The table below shows a summary of the medical staffing metrics in surgery at Whittington Hospital compared to the trust's targets, where applicable:

	Surgery annual staffing metrics						
	September 2018 to August 2019						
Staff Group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	12%	3.5%			
All staff	473.6	15%	10%	12.8%			
Medical staff	132.6	7%	1%	0.8%	7,704 (3%)	2,216 (1%)	963 (<1%)

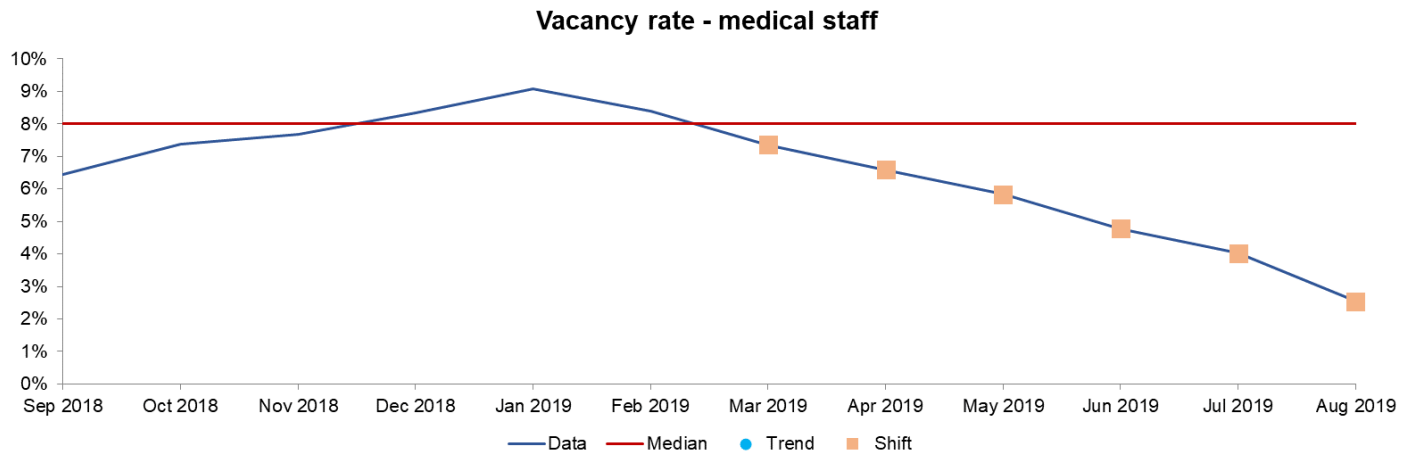
(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

The medical staff matched the planned number.

Medical staffing rates within surgery were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for sickness, bank use and agency use. There is not enough variation in the medical staff turnover rates over the last 12 months to comment on the performance of this metric over time.

Vacancy rates

The service had reducing vacancy rates for medical staff.



Monthly vacancy rates over the last 12 months for medical staff shows a shift from March 2019 to August 2019.

(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover rates

The service had reducing turnover rates for medical staff. Medical staff reported they were supported well and trained appropriately within the surgery services.

Sickness rates

The service had reducing sickness rates for medical staff.

Bank and locum staff usage

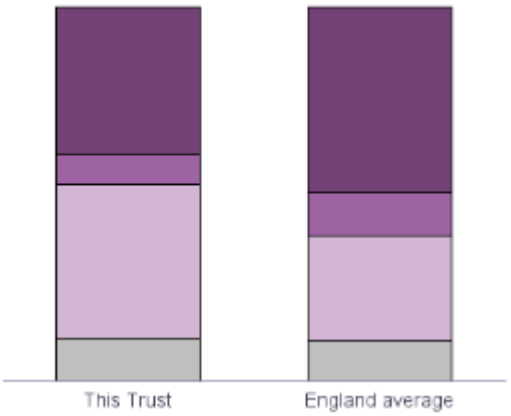
The service had reducing rates of bank and locum staff. Staff reported bank medical staff were used within surgery services.

Staffing skill mix

The service had a mostly good skill mix of medical staff on each shift and reviewed this regularly. However, staff reported on Thorogood ward, it was sometimes difficult to ensure a good skill mix.

In June 2019, the proportion of consultant staff reported to be working at the trust was lower than the England average and the proportion of junior (foundation year 1-2) staff was the same as the England average.

Staffing skill mix for the whole time equivalent staff working at Whittington Health NHS Trust



	This Trust	England average
Consultant	39%	50%
Middle career^	8%	11%
Registrar Group~	41%	28%
Junior*	11%	11%

^ Middle Career = At least 3 years at SHO or a higher grade within their chosen specialty
~ Registrar Group = Specialist Registrar (StR) 1-6
* Junior = Foundation Year 1-2

(Source: NHS Digital Workforce Statistics)

Records

Staff did not always keep detailed records of patients' care and treatment. Staff did not always update and fully document information in patient records.

We reviewed 11 sets of patient records and found most were not fully completed. We found five out of six were missing treatment escalation plans and three out of six were missing hip fracture scores. We checked five fluid balance charts all were only partially completed as most did not have totals and had missing entries. Patient food intake charts were also inconsistently completed.

Whilst the records we reviewed included the date, they did not always include the time. In addition, they did not always have a printed name and designation.

The patient records however included required documentation for risk assessments including falls risk assessment, pain management, pressure care risk assessment and the MUST assessment. It was also clear which member of the multidisciplinary team had completed an entry. All entries showed a discussion and involvement of the patient in their care planning and treatment.

When patients transferred to a new team, there were no delays in staff accessing their records. We saw all information needed for patient ongoing care was shared appropriately, in a timely way and in line with relevant protocols.

Records were stored securely. Staff completed patient records electronically and in paper formats which were stored in lockable cabinets on the wards. Staff also completed a daily record of care provided to patients which were kept at the end of each patient's bed.

Medicines

Although the service used systems and processes to safely prescribe and administer medicines they did not always record and store medicines safely.

Staff followed systems and processes when safely prescribing, administering, and mostly storing medicines, however, medicines were not always safely recorded. Staff stored all medicines, including intravenous fluids, securely on all wards visited. Staff administered medicines as prescribed to patients with few omitted doses. All controlled drugs were stored in locked cupboards.

Throughout the hospital an online software which was used to interlink patients who were transferred across wards. Across surgical services an electronic medication administration system was used, which recorded patient's allergies, fluids, warfarin of a varied dose and Insulin. The system was supplemented with separate paper charts (referenced on the electronic prescription) specifically for the prescription and administration of variable dose warfarin, oxygen and intravenous infusions. Staff completed venous thromboembolism (VTE) assessments for patients.

During our inspection we reviewed the controlled drug (CD) registers in three theatres and found two examples where fentanyl was being disposed of but no witness signature was recorded. This was not in line with best practice. The trust were reviewing and updating their policy on medicines management to improve staff understanding and compliance in this area.

We inspected drug storage areas, and found all medicines and consumables were stored properly and the rooms were clean and tidy. However, we found on the Coyle ward drug room the temperature regularly raised above the recommended 25-degree Celsius. On one day of our inspection, we found, the temperature was persistently at 27 C, despite an air conditioning unit operating. This was escalated, and we were informed it was put on the risk register with facilities. All medicines fridges were connected to the central Kelsius digital monitoring system.

However, following our inspection the trust reported they had implemented actions. These consisted of, managers planned to develop a communication strategy to raise trust wide awareness and understanding of the Standard Operating Procedure (SOP) for the procedure for management of medicines in stored rooms outside of recommended temperature ranges. They also planned to incorporate a review of adherence to the SOP within the Safe and Secure Handling Audit, an acute trust completed six monthly which included a community and clinics annual rolling programme.

We observed staff followed the correct procedures of administrating Controlled Drugs (CD) and antibiotics to patients. We also found controlled Drugs (CDs) cupboards, oral solid and liquid medicines spot checked stocks were in order. All unwanted medicines were returned in a locked return to the pharmacy bin. Closed-Circuit Television (CCTV) surveillance were in place in some drug storage rooms.

All resuscitation trollies were checked on the 22nd of each month, the resus call number was 2222, for ease of memory. The lead resus officer carried out an audit after the 22nd to ensure compliance. Trollies were updated with the medicines contained in the drawers and all oxygen cylinders, which included one per trolley were full. However, we found one Intravenous (IV) fluid had expired. We also found on Thorogood ward and Mercers ward out of date blood culture bottles from the sepsis bag on the resuscitation trolley, however, we informed the ward manager and these items were replaced immediately, we checked the following morning of our inspection. once informed both wards replaced these immediately.

Staff reviewed patient's medicines regularly and provided specific advice to patients and carers about their medicines. Patients we spoke with reported they felt staff discussed their medication with them, and informed them why they were required to take which medication. Patients were also informed of their medication needs following discharge.

A detailed algorithm was available on the trust Intranet to help clinicians in decision making of Total Parenteral Nutrition (TPN) and nutritional requirements. On-call gastroenterologist were available to contact for advice and endorsement.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. For example, the electronic medication administration system JAC flagged up patients due to have medications, especially patients receiving Parkinson medicines and poly-pharmacy. The Parkinson nurse provided a reminder clock, however this was not for the current patient. These sort of aides were obtained by the ward staff from the relevant charity such as the Parkinson's UK.

Staff followed current national practice to check patients had the correct medicines. On the surgical wards Patient's own medicines (PODs) were used and were properly assessed in line with guidance. The medicines management technician targeted high risk patients to counsel To Take Away (TTA) medication, this mostly included patients who had undergone bariatric surgery.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff were aware of the process for reporting incidents. The electronic system included an ALERT tab, which informed staff of any patient safety information, for example we saw one patient's allergies were clearly recorded on the system.

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. For example, when medical staff completed the ward round.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff we spoke with all confirmed how to report an incident, and what a reportable incident was. Staff reported incidents using an electronic reporting system which staff told us they could access and complete.

Staff raised concerns and reported incidents and near misses in line with trust policy. Staff we supported to report incidents and received guidance in the process if required.

Never Events

The service had never events within the surgical services. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2018 to September 2019, the trust reported four never events for surgery.

Two of the never events were reported as wrong site surgery:

- November 2018 - peripheral nerve stimulation on the wrong side.
- May 2019 - paravertebral block inserted on the wrong side.

Two further never events were reported as wrong implant/prothesis. These never events were identified by the trust's review of all orthopaedic fracture fixation plates fitted which was undertaken in response to the release of a patient safety alert on 8 February 2019:

- January 2019 - wrong orthopaedic fracture fixation plates fitted.
- March 2019 - wrong orthopaedic fracture fixation plates fitted.

(Source: Strategic Executive Information System (STEIS))

The trust reported a further never event prior to our inspection. The incident occurred in the dental services and included the extraction of wrong permanent upper molar. The trust reported they informed the patient immediately and counselled them on the implications of future restorative/ prosthetic dental treatment. We were informed the incident highlighted the need to reinforce staff awareness and review mechanisms for auditing and monitoring practice to ensure the use of the checklist is fully embedded.

To achieve this the trust took the following immediate actions; all dental staff were informed of the Never Event and the importance of the use of checklist for all invasive procedures was reinforced. A debrief with the clinician involved took place. The trust reviewed processes to build in a regular audit of practice to ensure appropriate use of checklists. Staff we spoke with during our inspection confirmed their awareness and shared learning of never events.

Managers shared learning about never events with their staff and across the trust. Staff we spoke with told us of the never events across the surgical services and training which took place following the incidents.

On the wards, messages were displayed including, learning from incidents, for example, "Air valves to be used only during nebulising and removed, cleaned and stored in designated safe locations, all staff and agency are aware of this".

Managers shared learning with their staff about never events that happened elsewhere. Following a route course analysis, an action plan was implemented to document the steps taken and shared

learning following the never events. Managers informed us they spent time with staff discussing never events following the recent reported incidents. We were informed staff had an awareness of what possible 'obvious' never events were, however they did not have an awareness of others. To increase staff awareness managers provided training to support staff and develop knowledge. Managers were assured staff were aware of all possible never events following specific training.

We spoke with staff regarding a never event which was not initially reported as a never event. The staff member took responsibility of this incident and informed us they completed training to update them in the process. The staff member displayed a list of all the possible never events in their office to refer back to at any time, in response to the never event not being reported correctly. This was subsequently reported as a never event.

Breakdown of serious incidents reported to STEIS
Staff reported serious incidents clearly and in line with trust policy.

Trust level
In accordance with the Serious Incident Framework 2015, the trust reported six serious incidents (SIs) in surgery which met the reporting criteria set by NHS England from October 2018 to September 2018. This includes the four never events described above. A breakdown of incidents by incident type are below.

Incident type	Number of incidents	Percentage of total
Surgical/invasive procedure incident meeting SI criteria	4	66.7%
Pending review	1	16.7%
Screening issues meeting SI criteria	1	16.7%
Total	**6**	**100%**

(Source: Strategic Executive Information System (STEIS))

Staff understood the duty of candour. They were open and transparent, and gave patients and families a full explanation if and when things went wrong. All staff we spoke with were aware of the duty of candour and knew the circumstances to which they applied it. A shared culture of being open and honest was clear across surgical services and this enabled staff to take responsibility and be supported to do the right thing.

Staff received feedback from investigation of incidents, both internal and external to the service. Staff we spoke with confirmed they received feedback when they reported an incident on the online reporting system. Information was also displayed on the wards for staff and patients which included the message of the month for learning from incidents. Around wards there was also learning from serious incidents displayed for staff and patients.

Staff met to discuss the feedback and look at improvements to patient care. Monthly governance meetings held discussions on incidents, investigations, and feedback. During the monthly matron and ward managers meetings, feedback from incidents was reviewed to improve patient care. Daily handovers and weekly Friday afternoon handovers included discussions of any incidents and feedback received.

There was evidence that changes had been made as a result of feedback. For example, it was identified from serious incidents there were some issues around weekend staff cover. In response managers facilitated a comprehensive handover every Friday afternoon from 2pm to 5pm which

included staff from different disciplines. Managers reported there had been a significant improvement in weekend ward rounds particularly on Mercers ward.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers completed a route cause analysis report and an action plan after each serious incident. They said they spoke with the staff involved about the learning from the incident. Managers debriefed and supported staff after any serious incident. Staff across all levels confirmed they were supported by managers.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information, however they did not always share it with staff, patients and visitors.

Safety thermometer data was not displayed on all wards for staff and patients to see. However, we asked ward managers about the safety thermometer data and they were easily able to access it. Following our discussion, one ward manager displayed October 2019 data on the ward. Following our inspection the trust stated they would review ward quality and safety boards to ensure all relevant safety thermometers data was displayed.

The Safety Thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

The safety thermometer data showed the service mostly achieved harm free care within the reporting period. For October 2019 both Mercers and Thorogood wards were 100 percent harm free care. However, Coyle ward was slightly lower at 92.3 percent.

Staff used the safety thermometer data to further improve services. Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported 11 new pressure ulcers, two falls with harm and no new urinary tract infections in patients with a catheter from August 2018 to August 2019 for surgery.

Prevalence rate (number of patients per 100 surveyed) of pressure ulcers, falls and urinary tract infections in patients with a catheter at Whittington Health NHS Trust

Total Falls (2)

Total CUTIs[3] (0)

1 Pressure ulcers levels 2, 3 and 4
2 Falls with harm levels 3 to 6
3 Catheter acquired urinary tract infection level 3 only

(Source: NHS Digital)

Is the service effective?

Staff always had access to up-to-date, accurate and comprehensive information on patients' care and treatment. All staff had access to an electronic records system that they could all update.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers did not always check to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff mostly followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. The service followed national guidance including National Institute for Health and Care Excellence (NICE), Royal College of Surgeons (RCS) and the Association of Anaesthetists of Great Britain and Ireland (AAGBI). The service supported staff to follow the national guidelines as it had local guidelines and policies. Staff had access to the trust intranet where all policies, protocols and procedures were stored. The trust measured compliance with the national standards through local and national audits.

Pathways in place followed guidance, for example the fractured neck of femur pathway. We reviewed six patient records and all were completed to a good standard of the perioperative care plan. All records included checklists and the sign in and time out were all completed and signed.

The service compliance with the National Hip Fracture Database for 120 day follow up following discharge of hip fracture patients had increased. Staff reported previous difficulties were due to patients not answering their telephone for the follow up call. Therefore, staff reported patients were seen in clinics for follow up to increase results. However this was not always achieved for patients who lived out of the area or had dementia. The compliance was increasing from 57.7 percent in 2017 to 69.6 percent in 2018.

However, we found staff did not record the daily checks of essential clinical equipment in theatres in line with AAGBI standards. We found managers did not always check to make sure staff followed this guidance.

The service assessed people's physical, mental health and social needs holistically. For example, staff assessed patient needs on admission, we saw NICE guidelines were followed for patients receiving Intravenous (IV) fluid therapy and patients were assessed to be at risk of VTE in accordance with NICE guidance.

Processes were in place to ensure there was no discrimination, including those under the grounds of protected characteristics under the equality act, when making care and treatment decisions. For example, staff had received specific training and admission documents identified where patients had a protected characteristic.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. Staff reported they received training on the Mental Health Act and the Mental Capacity Act. We spoke with nursing staff who demonstrated understanding and regard to the mental health act. Staff gave examples of actions taken to support patients with mental health concerns. Staff also referred patients with mental health concerns to the trust mental health liaison service. Staff accessed the mental health lead for advice and guidance when required. Staff further protected patient rights, by respecting their confidentiality, and supporting them whilst waiting for specialist support.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. The service ensured a well-structured handover, which included a thorough discussion of all patients. The handover provided input provided from consultants and patient specialists. Each patient was discussed in detail including their medical condition, emotional well-being and social circumstances.

To support older people who were frail or vulnerable, the service completed risk assessments of their physical, mental and social needs. Staff had support from the frailty team as and when required. Falls, bed rail and moving and handling risk assessments were also completed and documented in line with best practice and guidance for five patient records we reviewed.

The service told people when to seek further help and advised what to do if their condition deteriorated. The service also offered further support from specialist services including the dietitian, stoma nurse and the critical care outreach team (CCOT).

We saw sepsis screening and management was done effectively in line with NICE guideline 51. Staff were also appropriately trained on the sepsis screening tool and care bundle.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. Staff gave patients enough food and drink to meet their needs and improve their health. Staff ensured fresh water was available for patients on the wards, as well as offering hot

drinks including tea and coffee where appropriate. The service provided a choice of hot meals and sandwiches for in-patients. We saw staff taking orders from patients for their meals. Menu choices were comprehensive and included information on special dietary requirements, portion sizes and content and availability of snack boxes.

In pre-assessment, staff provided water for patients to drink. As part of the assessment, staff checked when patients last ate or drank, staff explained individual dietary preparations to patients prior to their procedure.

The service ensured appropriate nutritional support and effective management of nausea and vomiting. Posters promoting hydration were displayed on the ward.

Staff did not fully and accurately complete patient's fluid and nutrition charts where needed. We reviewed five patient records and saw staff had partially completed reviews of patients' nutritional and hydration needs. For example, for the fluid balance charts, most did not have totals and also had missing entries. Patient food intake chart was also inconsistently completed.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. Staff assessed patients using the Malnutrition Universal Screening Tool (MUST). Within the five patient records we reviewed, staff completed four MUST assessments and they appropriately referred onto the dietician, this was recorded in their patient notes.

Specialist support from staff such as dieticians were available for patients who needed it. There was a dietetic service available for patients on special diets. The dietetics team implemented a screening tool across the wards, staff were trained on the electronic system to document patient measurements for their BMI, dietary intake, surgery and sepsis score. Staff could also refer patients to a dietitian for advice and support after surgery.

Patients waiting to have surgery were not left nil by mouth for long periods. Patients attending for surgery were provided with information both verbally and through leaflets about their nutritional and hydration needs prior to and post-surgery. This included instructions relating to the period they needed to be nil by mouth prior to anaesthesia. The time was variable depending on the planned procedure and time of day the procedure was to be carried out. Patients we spoke with confirmed this information was clear.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patient's pain using a recognised tool and gave pain relief in line with individual needs and best practice. Pain assessments were completed on admission with an ongoing baseline assessment recorded on the patients National Early Warning Score (NEWS) electronic record. Pain assessments were completed in a number of ways, including the use of a verbal score or visual aids. Staff also recognised patient body language and non-verbal cues including facial expressions and body movement including muscle tension to identify patient pain score.

Patients received pain relief soon after requesting it. Patients we spoke with confirmed if they needed pain relief staff provided it in a timely response.

Staff prescribed, administered and recorded pain relief accurately. We reviewed five patient records and saw staff had carried out pain scores for the patients. This was to assess the level of pain the patient was in order to prescribe and administer appropriate pain relief medicine if

required. Staff used a basic pain score from 0-3 and recorded the results on a chart. The service contacted the pain relief team for advice and guidance as and when required.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. Outcomes for patients were mostly positive, consistent and met expectations, such as national standards. Managers and staff used audit results to improve patient outcomes. For example, staff used database audits for admissions, for example, staff looked at why patients were in hospital for longer than two, three or four days at a time.

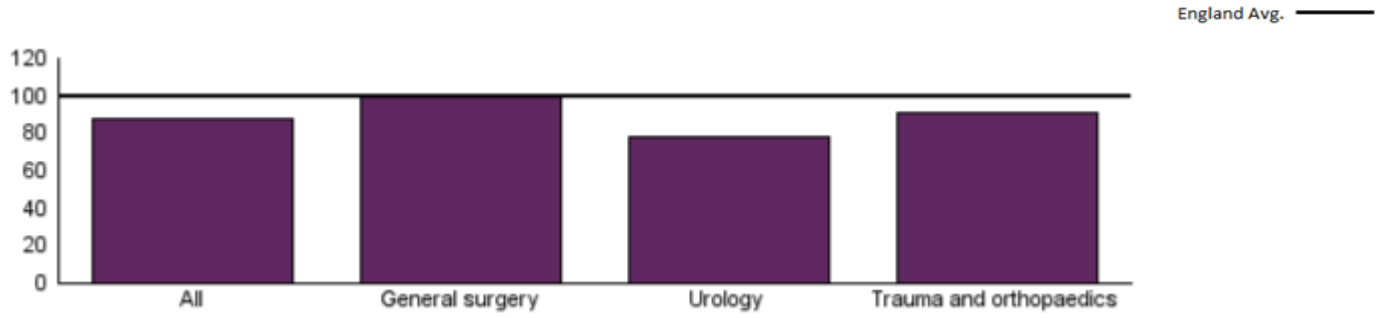
Relative risk of readmission

From June 2018 to May 2019, all patients at the trust had a lower than expected risk of readmission for elective admissions when compared to the England average.

General surgery, urology and trauma and orthopaedic patients at the hospital all had a lower than expected risk of readmission for elective admissions when compared to the England average.

The service had a lower than expected risk of readmission for elective care than the England average, as documented on the below table.

Elective Admissions – Whittington Hospital



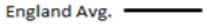
Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

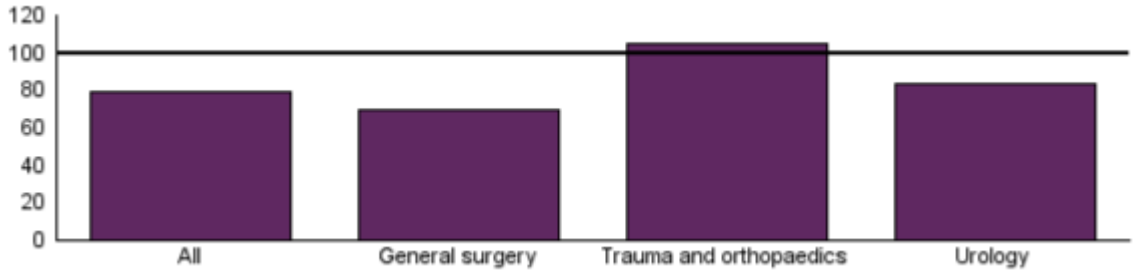
All patients at Whittington Hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average.

General surgery and urology patients at this hospital had a lower than expected risk of readmission for non-elective admissions when compared to the England average. Trauma and orthopaedics patients at this hospital had a higher than expected risk of readmission for non-elective admissions when compared to the England average.

The service had a mostly lower than expected risk of readmission for non-elective care than the England average. Trauma and orthopaedics was slightly above the England average, as shown in the graph table.

Non-Elective Admissions





Note: Ratio of observed to expected emergency readmissions multiplied by 100. A value below 100 is interpreted as a positive finding, as this means there were fewer observed readmissions than expected. A value above 100 represents the opposite. Top three specialties for specific trust based on count of activity

(Source: Hospital Episode Statistics - HES - Readmissions (01/06/2018 - 31/05/2019))

National Hip Fracture Database

The table below summarises Whittington Hospital's performance in the 2018 National Hip Fracture Database. For five measures, the audit reports performance in quartiles. In this context, 'similar' means that the trust's performance fell within the middle 50% of results nationally.

Metrics *(Audit indicators)*	Hospital performance	Comparison to other Trusts	Met national standard?
Case ascertainment *(Proportion of eligible cases included in the audit)*	108.3%	Better	Met
Crude proportion of patients having surgery on the day or day after admission *(It is important to avoid any unnecessary delays for people who are assessed as fit for surgery as delays in surgery are associated with negative outcomes for mortality and return to mobility)*	90.8%	Better	Met
Crude peri-operative medical assessment rate *(NICE guidance specifically recommends the involvement and assessment by a Care of the Elderly doctor around the time of the operation to ensure the best outcome*)	97.7%	Better	Did not meet
Crude proportion of patients documented as not developing a pressure ulcer *(Careful assessment, documentation and preventative measures should be taken to reduce the risk of hospital-acquired pressure damage (grade 2 or above) during a patient's admission); this measures an organisation's ability to report 'documented as no pressure ulcer' for a patient*	96.2%	Similar	Did not meet
Crude overall hospital length of stay *(A longer overall length of stay may indicate*	19.5 days	Similar	No current standard

that patients are not discharged or transferred sufficiently quickly; a too short length of stay may be indicative of a premature discharge and a risk of readmission)			
Risk-adjusted 30-day mortality rate *(Adjusted scores take into account the differences in the case-mix of patients treated)*	7.3%	Within expected range	No current standard

(Source: National Hip Fracture Database)

National Joint Registry

(Audit of hip, knee, ankle, elbow and shoulder joint replacements)

The table below summarises Whittington Hospital's performance in the 2018 National Joint Registry.

	Metrics ***(Audit measures)***	**Hospital performance**	**Comparison to other hospitals**	**Met national standard?**
Trust-level	**Case ascertainment (hips, knees, ankles and elbows)** (*Proportion of eligible cases within the trust that were submitted to the audit)*	95.0%	Better	Met
	Proportion of patients consented to have personal details included (*hips, knees, ankles and elbows)* *(Patient details help 'track and trace' prosthetics that are implanted. It is regarded as best practice to gain consent from a patient to facilitate entering their patient details on to the register)*	91.6%	Similar	Did not meet
Hospital level: Hips	**Risk-adjusted 5 year revision ratio (for hips excluding tumours and neck of femur fracture)** (*Proportion of patients who need their hip replacement 're-doing')*	1.3	Within expected range	Did not meet
	Risk adjusted 90-day post-operative mortality ratio (for hips excluding tumours and neck of femur fracture) *(Proportion of patients who die within 90 days of their operation*)	1.0	Within expected range	Met
Hospital level: Knees	**Risk-adjusted 5 year revision ratio (for knees excluding tumours)** (*Proportion of patients who need their knee replacement 're-doing')*	1.6	Within expected range	Did not meet
	Risk adjusted 90-day post-operative mortality ratio (for knees excluding tumours) *(Proportion of patients who die within 90*	1.0	Within expected range	Met

	days of their operation)			

(Source: National Joint Registry)

Bowel Cancer Audit

The table below summarises Whittington Health NHS Trust's performance in the 2018 National Bowel Cancer Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Case ascertainment *(Proportion of eligible cases included in the audit)*	79.7%	Fair	Good is over 80%
Risk-adjusted post-operative length of stay >5 days after major resection *(A prolonged length of stay can pose risks to patients)*	90.1%	Worse than national aggregate	No current standard
Risk-adjusted 90-day post-operative mortality rate *(Proportion of patients who died within 90 days of surgery; post-operative mortality for bowel cancer surgery varies according to whether surgery occurs as an emergency or as an elective procedure*)	13.6%	Within expected range	No current standard
Risk-adjusted 2-year post-operative mortality rate *(Variation in two-year mortality may reflect, at least in part, differences in surgical care, patient characteristics and provision of chemotherapy and radiotherapy*)	26.9%	Within expected range	No current standard
Risk-adjusted 30-day unplanned readmission rate *(A potential risk for early/inappropriate discharge is the need for unplanned readmission)*	24.5%	Within expected range	No current standard
Risk-adjusted 18-month temporary stoma rate in rectal cancer patients undergoing major resection *(After the diseased section of the bowel/rectum has been removed, the bowel/rectum may be reconnected. In some cases it will not and a temporary stoma would be created. For some procedures this can be reversed at a later date)*	51.3%	Within expected range	No current standard

(Source: National Bowel Cancer Audit)

National Vascular Registry
The trust did not participate in the 2018 National Vascular Registry.

(Source: National Vascular Registry)

National Oesophago-gastric Cancer Audit
(Audit of the overall quality of care provided for patients with cancer of the oesophagus [the food pipe] and stomach)

The table below summarises Whittington Health NHS Trust performance in the 2018 National Oesophago-gastric Cancer Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Trust-level metrics *(Measures of hospital performance in the treatment of oesophago-gastric (food pipe and stomach) cancer)*			
Case ascertainment *(Proportion of eligible cases included in the audit)*	81 to 90%	Better	No current standard
Age and sex adjusted proportion of patients diagnosed after an emergency admission *(Being diagnosed with cancer in an emergency department is not a good sign. It is used as a proxy for late stage cancer and therefore poor rates of survival. The audit recommends that overall rates over 15% could warrant investigation)*	19.1%	Could warrant investigation	No current standard
Risk adjusted 90-day post-operative mortality rate *(Proportion of patients who die within 90 days of their operation*)	Not eligible	Not eligible	No current standard
Cancer Alliance level metrics *(Measures of performance of the wider group of organisations involved in the delivery of care for patients with oesophago-gastric (food pipe and stomach) cancer; can be a marker of the effectiveness of care at network level; better co-operation between hospitals within a network would be expected to produce better results. Contextual measure only.*			
Crude proportion of patients treated with curative intent in the Cancer Alliance *(Proportion of patients receiving treatment intended to cure their cancer)*	33.6%	Worse	No current standard

(Source: National Oesophago-Gastric Cancer Audit)

National Emergency Laparotomy Audit
The table below summarises Whittington Hospital's performance in the 2018 National Emergency Laparotomy Audit. The audit reports on the extent to which key performance measures were met

and grades performance as red (less than 50% of patients achieving the standard), amber (between 50% and 80% of patients achieving the standard) and green (more than 80% of patients achieved the standard.

Metrics *(Audit measures)*	**Hospital performance**	**Audit's Rating**	**Met national standard?**
Case ascertainment *(Proportion of eligible cases included in the audit)*	97%	Green	Met
Crude proportion of cases with pre-operative documentation of risk of death *(Proportion of patients having their risk of death assessed and recorded in their notes before undergoing an operation)*	62%	Amber	Did not meet
Crude proportion of cases with access to theatres within clinically appropriate time frames *(Proportion of patients who were operated on within recommended times*)	93%	Green	Met
Crude proportion of high-risk cases (greater than or equal to 5% predicted mortality) with consultant surgeon and anaesthetist present in theatre *(Proportion of patients with a high risk of death (5% or more) who have a Consultant Surgeon and Anaesthetist present at the time of their operation)*	80%	Amber	Did not meet
Crude proportion of highest-risk cases (greater than 10% predicted mortality) admitted to surgery post-operatively (*Proportion of patients with a high risk of death (10% or more) who are admitted to a Critical/Intensive Care ward after their operation*)	86%	Green	Met
Risk-adjusted 30-day mortality rate *(Proportion of patients who die within 30 days of admission, adjusted for the case-mix of patients seen by the provider)*	13%	Within expected range	No current standard

(Source: National Emergency Laparotomy Audit)

National Ophthalmology Database Audit

(Audit of patients undergoing cataract surgery)

The trust did not participate in the 2018 National Ophthalmology Database Audit.

(Source: National Ophthalmology Database Audit)

National Prostate Cancer Audit

The table below summarises Whittington Health NHS Trust's performance in the 2018 National Prostate Cancer Audit.

Metrics *(Audit measures)*	Hospital performance	Comparison to other trusts	Met national standard?
Men with complete information to determine disease status *(This is a classification that describes how advanced the cancer is and includes the size of the tumour, the involvement of lymph nodes and whether the cancer has spread to different part of the body)*	95.4%	N/A	Did not meet
Percentage of patients who had an emergency readmission within 90 days of radical prostatectomy *(A radical prostatectomy involves the surgical removal of the whole prostate and the cancer cells within it; emergency readmission may reflect that patients experienced a complication related to the surgery after discharge from hospital)*	No data available	N/A	No current standard
Percentage of patients experiencing a severe urinary complication requiring intervention following radical prostatectomy *(Complications following surgery may reflect the quality of surgical care*)	No data available	N/A	No current standard
Percentage of patients experiencing a severe gastrointestinal complication requiring an intervention following external beam radiotherapy *(External beam radiotherapy uses high-energy beams to destroy cancer cells)*	No data available	N/A	No current standard

(Source: National Prostate Cancer Audit)

Adult cardiac surgery

The trust did not participate in the 2018 National Cardiac Audit.

(Source: National Cardiac Audit Programme)

Patient Reported Outcome Measures

In the Patient Reported Outcomes Measures (PROMS) survey, patients are asked whether they feel better or worse after receiving the following operations:

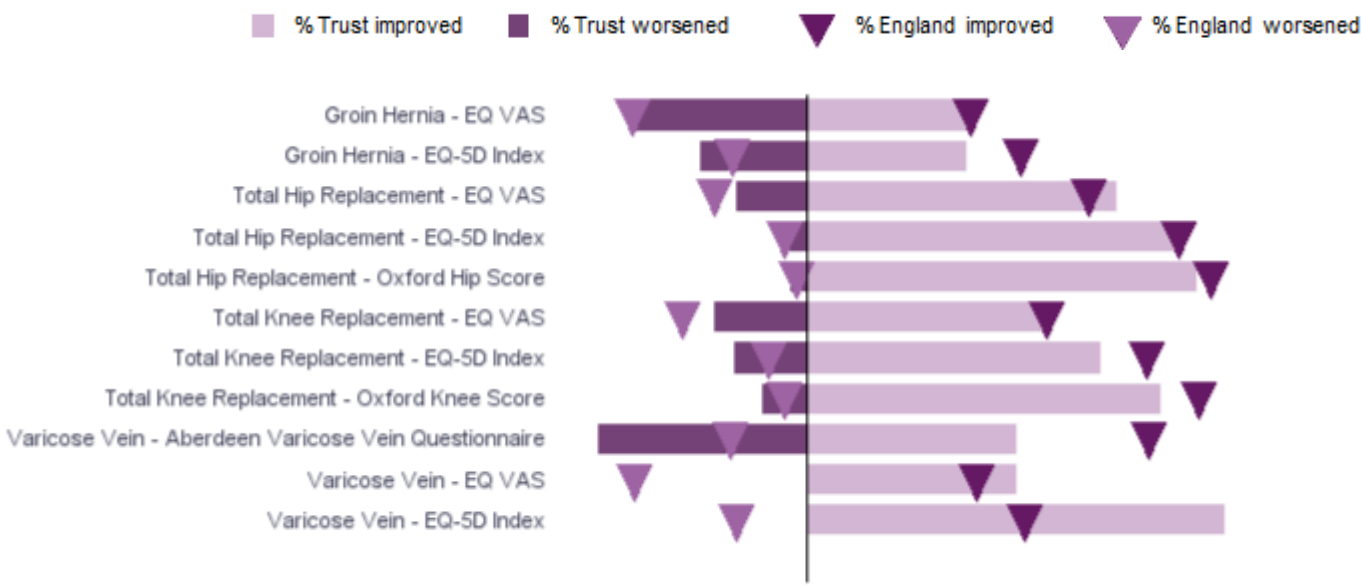
- Groin Hernias
- Varicose Veins
- Hip Replacements
- Knee replacements

Proportions of patients who reported an improvement after each procedure can be seen on the right of the graph, whereas proportions of patients reporting that they feel worse can be viewed on the left. These changes are measured in a number of different ways, descriptions of some of the indicators presented are below.

Visual analogue scale (EQ-VAS)
Visual analogue scale (EQ VAS) is, asking to mark health status on the day of the interview on a vertical scale. The bottom rate (0) corresponds to "the worst health you can imagine", and the highest rate (100) corresponds to "the best health you can imagine".

The EQ-5D-5L questionnaire has two parts. Five domain questions ask about specific Issues namely mobility self-care usual activities pain or discomfort anxiety or depression. The EQ-5D-5L uses 5 levels of responsiveness to measure problems. The range is; no problem - disabling/extreme.

The Oxford Hip Score (OHS) is a patient self-completion report on outcomes of hip operations containing 12 questions about activities of daily living, a simple scoring and summing system provides an overall scale for assessing outcome of hip interventions.



In 2016/17 performance on groin hernias was about the same as the England average for the EQ VAS score but worse than the England average for the EQ-5D index.

For varicose veins, performance was better than the England average and no patients reported deterioration in outcomes.

For hip replacements, performance was about the same as the England average.

For knee replacements performance was about the same as the England average.

(Source: NHS Digital)

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. For example, the pre-assessment department completed an audit of the spinal injection patients. The results demonstrated patients with no other comorbidities had longer time slots than required for their preoperative assessment. Managers recognised if patients did not identify to have other comorbidities on their screening questionnaire they were assigned smaller slots. This benefited patients as they were not in pre-assessment for longer than was required.

Monthly audits were completed on health and safety, fire and security, infection prevention and control including cannulas and catheters, and patient falls. The enhanced recovery lead nurse for orthopaedics collected data on colorectal surgery and appendectomy surgery for patients to attend a follow up clinic.

Managers shared and made sure staff understood information from the audits. Audits were discussed at the monthly matron and ward managers meetings. Information was cascaded down to staff through meetings and huddles.

Improvement was checked and monitored. For example, the pre-assessment department held an improvement working group every two weeks, with attendance from the ward sister, the matron and an anaesthetist. Discussions included how to improve patient care.

Competent staff

Whilst the service made sure staff were competent for their roles, not all staff had received an annual appraisal of their work performance. However, staff reported they received informal support as and when they required it.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff we spoke with stated they felt they had the right skills and knowledge to fulfil their role. The service had leads for specialised areas including mental health, learning disability and safeguarding. The service demonstrated effective multidisciplinary working this ensured consistency in meeting the needs of patients.

The service had a specialist stoma nurse, who had been providing stoma care for 22 years. The stoma nurse set up and facilitated three stoma care support groups outside of their working hours.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with confirmed they received relevant training as part of their induction. Both junior doctors and nursing staff reported they were also very well supported during their induction period.

Appraisal rates

Managers supported staff to develop through yearly, constructive appraisals of their work. Staff we spoke with confirmed they received a comprehensive appraisal, however not all areas of surgical services met the trust target. The matron reported appraisal rates were improving.

Whittington Hospital

From October 2018 to September 2019 79.1% of required staff in surgery received an appraisal compared to the trust target of 90%.

The breakdown by staff group can be seen in the table below:

Staff group	October 2018 to September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Medical and dental*	54	61	88.5%	90%	No
Nursing and midwifery registered	96	112	85.7%	90%	No
Additional professional scientific and technical	5	7	71.4%	90%	No
Estates and ancillary	5	7	71.4%	90%	No
Additional clinical services	27	39	69.2%	90%	No

Administrative and clerical	17	31	54.8%	90%	No
Allied health professionals	0	1	0.0%	90%	No
Total	**204**	**258**	**79.1%**	**90%**	**No**

* Note that data for medical and dental staff was provided separately by the trust and shows appraisal compliance as at October 2019.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Managers supported staff to develop through regular, informal discussions. For example, staff we spoke with confirmed they had access to support as and when they required it. They felt comfortable to ask for help and guidance from local managers. However staff did not report receiving regular clinical supervision.

The practice development nurses supported the learning and development needs of staff. They supported staff as and when required, they also introduced the huddles within pre-assessment to ensure shared learning across staff disciplines.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. Monthly matron and ward manager meetings were held to discuss information including incidents, complaints and audits. Ward meetings took place every two to three months and staff were informed consistently of any important information. This was cascaded through huddle meetings and information boards around the wards displayed information for staff. Staff told us they were sent any important information, feedback or shared learning by email.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff provided training days to increase development and increase staff skills and knowledge in particular areas and for local policy updates.

Staff dedicated Friday afternoons to provide a weekend handover of patients. Staff from all disciplines attended to share information on patient care. Following the handover a training element was provided to staff. The educational input was rotated through the month to provide staff with a variety of new learning modules. For example, one week focused on learning from mortality and morbidity reviews and the next week was governance.

Within pre-assessment healthcare clinics ran daily, where healthcare assistants completed patient blood pressure measurements to enable nursing staff to complete other patient assessments.

Across Coyle and Mercers wards managers planned to facilitate a team building programme to include the matron, ward managers and band 6's. The planned formalised programme would be in protected time and include a reflective practice model. The matron informed us the early learning identified had provided more clarity of roles.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. For example, when one member of staff transferred from one of the wards to the pre-assessment department, they requested additional support and were provided new competencies and a mentor to develop their skills and knowledge.

Managers made sure staff received any specialist training for their role. Staff who were recruited from overseas received support and guidance for their role. Mandatory training was completed within their first two weeks of employment. The surgical wards did not have a permanent practice development nurse (PDN), however, additional funds were sought and agreed for PDN support particularly regarding the completion of the objective structured clinical examination (OSCE). The system of preceptorship was positive for staff and contributed to the retention of overseas staff.

It was mandatory for health care assistants (HCA) to complete the Care certificate either within the trust or with an alternative trust, if appropriate, and evidence was provided to show they completed it. Additional roles for HCAs included the assistant practitioners with competency to support. And the nursing associate, which was a role registered with the Nursing and Midwifery Council (NMC). The nursing associate role included a wider range of duties and responsibilities including some administration of medication. Managers reported this was a well developed role.

Medical staff received training specific to their role, for example registrars received in house teaching and training days including advanced trauma life support (ATLS). Foundation year 1 (FY1) Doctors had teaching days every Tuesday and Thursday and every Friday morning they had a case-based discussion with senior staff.

Band 5 physiotherapists rotated every four months to increase their knowledge and development in different areas across surgical services. One physiotherapist we spoke with reported how supported the team was and how they were given the responsibility to learn new skills whilst being supported by senior staff when required.

Managers identified poor staff performance promptly and supported staff to improve. Managers followed trust procedures for staff performance management. Staff were supported throughout their probation period and any further training or development was identified to improve staff performance. Managers monitored staff sickness rates to ensure the well-being of patients and support them to improve their performance when required.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. The service demonstrated effective multidisciplinary working, for example, nursing and medical staff communicated to provide continuity of care for patients.

Staff of all levels were recognised as part of the team on the wards. For example, a member of staff informed us “the house keepers were not just house keepers, they were part of the team”. We observed how effectively the service worked together to benefit patients.

Within the pre-assessment department, multidisciplinary meetings occurred every Tuesday afternoon. They included attendance from staff nurses, anaesthetist and geriatrician to discuss patient detail of what was required for the patient care and by who.

We observed effective multidisciplinary working for the joint school for hip and knee replacements. The staff attendance included clinical nurse specialists, the pain team, pharmacy and physio therapy.

However, the daily morning handover did not include staff from all disciplines, we observed two ward handovers and one theatre staff briefing, although the discussions were in depth and included patient medical condition, emotional well-being and social circumstances, they were only in attendance from the nursing team. Ward managers informed us following the handover they passed the information onto the physiotherapists (PT) and occupational therapists (OT) this ensured continuity of care for patients.

However, the service completed a weekly handover for staff across all disciplines every Friday from 2pm to 5pm. Time was provided to ensure handover for on call staff was consistent and

included all relevant patient detail. Following the handover teaching was spent to support staff in particular topics.

During our inspection we also observed a board round, which included staff from physiotherapy, occupational therapy and the ward manager. We observed staff had a good knowledge of patients and discussions ensured staff were respectful and considerate of the individual including family relationship dynamics. However, there was no representative from medical or surgical staff as a result nursing staff had to spend additional time chasing teams for decisions for example for TTA's.

Mortality and Morbidity meetings occurred quarterly with multidisciplinary staff including the enhanced recovery lead nurse, the pain team, physiotherapists and occupational therapists. Discussions were around patients with complications, hips and knee replacements for both elective surgery and trauma.

In pre-assessment staff made appointments available for patients to 'drop in'. For example, patients who attended clinic appointments could access pre-assessment the same day. Staff worked together to ensure all information was available for staff across services on the patient pathway.

MSG ward rounds took place twice a week and included attendance from a consultant microbiologist, pharmacist and the ward team. The trust had a dedicated consultant antimicrobial pharmacist. The ward round demonstrated a teaching culture and supported staff with specific training to increase patient care.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff across disciplines were available at the same time to support patients. For example, staff held patient meetings when required to discuss patient treatment and care plans. Staff from different disciplines included their specialist input to ensure effective care for patients. To support patients with a learning disability or dementia nurses provided one to one support for patients.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression. Staff we spoke with informed us they made a referral to the trust mental health liaison team to access specialised support for patients who required it. Staff worked together and communicated to share information to ensure patients received specialist help and care.

Seven-day services

Key services were not always available seven days a week to support timely patient care.

The surgical services consisted of three surgical wards and five theatres including orthopaedics, trauma and emergency, general surgery, day surgery and urology. The service had two recovery rooms, one for inpatients which had nine beds and one for day surgery which had five beds. There was a pre-assessment department which was open Monday to Friday with occasional Saturday's to meet the demand.

The service had a Day Treatment Centre (DTC) which operated Monday to Friday 7:30pm until 8pm. Discharges were seven days a week, with complex discharges arranged for Thursdays to ensure specialist care packages.

Consultants did not lead daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on the care pathway.

We were not assured patients were reviewed daily by consultants on all wards, from records we reviewed on Coyle Ward, the consultant ward round was every 48 hours not daily as recommended. The matron we spoke with did not confirm an awareness of any formal monitoring or audit for the consultant ward round.

However, following our inspection the trust reported they were to review consultant job plans for all specialties on and using the surgical wards to ensure seven-day cover for consultant led ward rounds is delivered. Compliance will be monitored by the ward sisters and Matron for Surgery and any gaps to be escalated to the appropriate Integrated Clinical Service Unit (ICSU) Clinical Director on a weekly basis.

It was identified from serious incidents there were some issues around weekend cover. However, in response to the incidents there was three hours protected time designated on Friday afternoons for a comprehensive handover and weekend plan. Mortality and Morbidity discussion and teaching also took place during this period. There has been a significant improvement in weekend ward rounds on Mercers ward in particular.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week. Consultants were available on call 24 hours a day and at weekends. Staff reported they could access the mental health liaison team and could seek advice and guidance from the mental health lead. The service had access to the pain management team.

Staff also had access to the bariatric clinical nurse specialist, the spinal pain nurse and staff reported they could also easily resolve any issue with the dermatology team. The service had access to emergency endoscopy, on call physio therapists, occupational therapists and the on-call pharmacist. However, the service did not have access to dietetic services on call.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.
The service had relevant information promoting healthy lifestyles and support on the wards. Information leaflets included:

- Smoking cessation
- Pressure ulcer prevention
- Falls prevention
- Patient guides on management of health and surgical conditions
- Macmillan information centre

Staff assessed each patient’s health when admitted and provided support for any individual needs to live a healthier lifestyle. Information leaflets for all surgical procedures were available and given to patients at pre-assessment clinic.

Bariatric patients were supported with dietetic advice from the trust’s dietitian service.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients’ consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff received mandatory training on The Mental Capacity Act (MCA) this gave them the skills and knowledge to assess patient capacity. Staff completed mental capacity assessments and carried out best interest assessments where patients lacked capacity.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff appropriately asked patients for their consent and documented it in patient records. When patients could not give consent, staff made decisions in their best interest, considering patients' wishes, culture and traditions. For example, on one patient record we reviewed, we found initial consent was documented due to patient having capacity. There was a delay to surgery and the patient capacity changed. The new consent form gave reasons why and the best interest decision, based on individual patient preference, was documented clearly on the patient record.

Staff made sure patients consented to treatment based on all the information available. Staff clearly explained treatment and care information to patients and patients received procedures details at pre-assessment. Staff explained why patients required medication, this ensured they understood their treatment before consenting. Patients we spoke with confirmed they understood their care and treatment plan and felt they were provided with all relevant information before giving consent to their procedure.

Staff clearly recorded consent in the patients' records. We reviewed six patient records and saw patient consent was recorded in them all.

Mental Capacity Act and Deprivation of Liberty training completion
Nursing and clinical staff received and kept up to date with training on the Mental Capacity Act, however, not all staff had completed training on Deprivation of Liberty Safeguards.

Whittington Hospital
The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

The trust reported that their safeguarding adults level 1 module provides training covering MCA level 1 and the safeguarding adults level 2 module covers MCA level 2 and DoLS training.

A breakdown of compliance for MCA/DOLS training modules as at 31 August 2019 at Whittington Hospital for qualified nursing staff in surgery is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	115	115	100.0%	90%	Yes
Safeguarding adults level 2	99	113	87.6%	90%	No

In surgery the target was met for one of the two MCA/DOLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DOLS training modules as at August 2019 at Whittington Hospital for medical staff in surgery is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	117	117	100.0%	90%	Yes
Safeguarding adults level 2	53	117	45.3%	90%	No

In surgery the target was met for one of the two MCA/DOLS training modules for which medical staff were eligible. The trust did not meet the target for safeguarding adults level 2 with 45% of staff having completed this module.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Staff we spoke with understood the Mental Health Act and the Mental Capacity Act. The service had access to the mental health liaison team to provide support for staff as and when they needed it. Staff we spoke with were also aware of the mental health lead.

Managers did not monitor the use of Deprivation of Liberty Safeguards, or make sure staff knew how to complete them. For example, we reviewed two Deprivation of Liberty Safeguards records and found one was completed and in date, however, the other was not signed, did not include a date or expiry date and the urgent authorisation page was not completed.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Policies were available on the trust intranet. Staff we spoke with explained the mental capacity assessment and how to apply the Deprivation of Liberty Safeguards in line with policy and training.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. Staff we spoke with demonstrated an understanding and awareness of the Mental Capacity Act.

Staff implemented Deprivation of Liberty Safeguards in line with approved documentation.

At the time of our inspection there had not been any involvement at Matron level for the development and implementation plans in relation to the upcoming introduction of the Liberty Protection Safeguards.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way.

Patients we spoke with confirmed staff were very courteous, respectful towards them and ensured they introduced themselves. Most patients reported they were very happy with the care they received telling us staff were very caring from greeting them through to discharging them. One patient described staff as “angels” with another informing us “staff were very supportive and have done everything possible to make me comfortable here”.

Throughout our inspection we saw staff continuously welcome patients and those who accompanied them in a polite and friendly manor. Staff at all levels took the time as they walked by to check on patients and their loved ones. Patients and relatives we spoke with were grateful for this interaction and this helped the hospital feel as normal as possible for patients.

Patients said staff treated them well and with kindness. Patients and relatives we spoke with confirmed staff introduced themselves and explained their role and involvement in the patient care and treatment. We observed staff politely meet and greet patients and their relatives in a friendly way. Patients told us staff got them whatever they needed with one patient informing us staff always put themselves out and when they said they were going to do something they did it.

Staff followed policy to keep patient care and treatment confidential. The surgical services kept records securely stored in lockable cabinets when not in use to adhere to patient confidentiality policy. Throughout our inspection we observed staff discretely sharing information between staff groups, during handover and staff huddles, to keep patient care and treatment confidential.

Patients we spoke with reported they felt their privacy and dignity was respected throughout their care and treatment. For example, privacy was respected through drawing curtains when appropriate and staff knocked on doors before entering side rooms. One patient told us they observed staff with the other patients on the ward and reported staff always respected patient privacy.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff received training to support and respect the individual needs of patients. Staff could access the mental health lead for advice and guidance to support and care for patients with mental health needs. During our inspection we observed staff displayed a non-judgemental attitude when caring for patients. One patient we spoke with reported “there was no discrimination staff knew my history and treated me as normal”.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The service had an awareness and understanding for different patient needs. Menus included different option choices for patients with personal, cultural, social and religious needs. Staff wore rainbow lanyards to promote inclusivity of patients of Lesbian Gay Bisexual and Transgender (LGBT) community. Posters were displayed to explain and promote the rainbow lanyards to patients and those who accompanied them.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patient's personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Patients told us how empathetic all staff were towards them during their care and treatment. Some patients explained they were nervous about their procedure and staff reassured them and comforted them.

One patient informed us of how nervous they were prior to their procedure and had decided against having it. The patient reported the surgeon contacted them at home by telephone and went through the process in detail including information to inform their decision. The patient was reassured to have their procedure and reported they were grateful for the communication with the surgeon.

We observed staff taking time to talk with patients and those who accompanied them. Staff were supportive and helped people during this time. Patients we spoke with confirmed staff were very patient with them and gave them time to ask questions and repeated information as and when required.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity. The surgical wards had side rooms to support patients if required and appropriate. In pre-assessment if patients became upset following news they received staff informed us they supported them by offering them a hot drink and a quiet area to talk. They followed patient wishes to wait with them or leave them to gather their thoughts. Managers reported they would ensure patients who were either not accompanied by anyone or had mental health needs or a learning disability were appropriately supported whilst in the hospital. In pre-assessment staff also used consultation rooms which were not in use to maintain patient privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. During our inspection staff continuously demonstrated empathy towards patients and to their loved ones. Staff appeared to have appropriate skills and knowledge to give them an awareness and understanding of patients needs during difficult times.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. Patients were provided with information to inform them of their care and treatment. Leaflets were available to patients to support them with their care and treatment following hospital discharge. The information included contact numbers for further care services or specialists.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Information was provided to patients at pre-assessment. This comprised of a booklet detailing all aspects of care preoperatively, perioperatively and post operatively. Patients we spoke with confirmed they understood their treatment plan and reasons why they received their procedure.

Discharge information was provided to patients to inform them of any home care or follow up care and treatment. Patients we spoke with reported they were consistently updated with information and felt involved in their care and treatment throughout the process.

Staff talked with patients, families and carers in a way they could understand and used communication aids where necessary. Staff reported they rephrased things and confirmed patients understood what they were told before moving on. Illustrations were used in some areas to visually explain aspects of care to patients.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service collected patient feedback through Friends and Family

Test. The surgical dashboard was displayed on wards, which included results from the Friends and Family Test.

Staff supported patients to make advanced decisions about their care. Staff we spoke with encouraged patients to make decisions about their care, and they supported patients with the process. Patients and their relatives explained they felt involved in their care and treatment and felt completely included in any decisions made. Patients also confirmed staff supported them with their recovery and self-care.

Staff supported patients to make informed decisions about their care. The service provided patients with relevant guidance and information to support them to make decisions about their treatment. Correct information in the correct format was provided to patients to enable them to make decisions about their care. Information was provided to patients which included risks, pre and follow up details to ensure patients were fully aware of all aspects of their care to make informed decisions.

A high proportion of patients gave positive feedback about the service in the Friends and Family Test survey. Of the patients who provided feedback, 100 percent would recommend the service for wards Coyle and Mercers, 97.1 percent would recommend the service for Thorogood ward and 92.6 percent would recommend the service for theatres.

Patients gave positive feedback about the service. The ICSU board report documented complaints and compliments received, we saw the report for September 19, which included comments such as, “Mercers staff are fabulous and make a difficult time all the easier with their dedication, professionalism, kindness and compassion. The ward has a positive energy thanks to all of its staff ”.

Staff could give examples of how they used patient feedback to improve the quality of care they provided. For example, patient feedback included the level of noise from visitors in the evening. The services displayed posters requesting visitors to keep the level of noise down when seeing their relatives as it disrupts the other patients. The posters also included the request of minimal noise of technical equipment again to respect the other patients. Managers reported this improved the service for patients.

Friends and Family test performance

The Friends and Family Test response rate for surgery at Whittington Health NHS Trust was 21% which was worse than the England average of 27% for July 2019.

A breakdown of response rate by ward can be viewed below.

Friends and family test response rate at Whittington Health NHS Trust, by ward

Ward name	Total Resp[1,2]	Resp. Rate	Percentage recommended[3]												Annual perf[1]
			Aug-18	Sep-18	Oct-18	Nov-18	Dec-18	Jan-19	Feb-19	Mar-19	Apr-19	May-19	Jun-19	Jul-19	
MERCERS	371	26%	100%	100%	82%	86%	88%	89%	100%	98%	100%	100%	91%	100%	95%
COYLE	326	16%	88%	86%	98%	95%	89%	100%	87%	96%	94%	90%	65%	87%	91%
DAYCASES	237	4%			97%			98%							98%
THOROGOOD	197	29%	100%	84%	97%	88%	100%	96%	100%	87%	100%				94%

Key: Highest score to lowest score — 100% | 50% | 0%

1. The total responses exclude all responses in months where there were less than five responses at a particular ward (shown as gaps in the data above), as well as wards where there were less than 100 responses in total over the 12 month period.

2. Sorted by total response.
3. The formatting above is conditional formatting which colours cells on a grading from highest to lowest, to aid in seeing quickly where scores are high or low. Colours do not imply the passing or failing of any national standard.

(Source: NHS England Friends and Family Test)

We obtained the FFT October 2019 results whilst we were on site, the table below reflects the figures.

Ward	Response rate	Would recommend
Coyle	14.2%	100%
Mercers	63%	100%
Thorogood	37.6%	97%
DTC	17.6%	98.6%

Coyle ward had a low response rate for October, we discussed this with the Matron who reported the reason was due to a change in working hours for the ward receptionist, they were looking to add to the volunteer hours already in place to support improvement.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the changing needs of the local population. People could access the service close to their home when they needed it. Arrangements to admit, treat and discharge patients were in line with good practice.

Surgical services were available seven days a week including surgical theatres and wards. The pre-assessment department operated from Monday to Friday, with appointment slots available on occasional Saturdays to meet the demand. Managers informed us this was not a regular occurrence, and they had not received any feedback of patients requiring pre-assessment appointments of an evening or at the weekend.

The pre-assessment department also met the needs of patients who “dropped in” for a pre-assessment appointment following their clinic or speciality appointment. This ensured patients did not need to return to the hospital at a later date, as they could access the services the same day.

The changes regarding all elective joint procedures to be under a local NHS trust were decided from patient and public contribution. This included public consultations as well as commissioner consultations to ensure service delivery met the needs of the local public.

The service provided a follow up clinic for elective patients, led by an enhanced recovery lead nurse the follow up included a telephone call three days after discharge. For example, if a patient had an issue with their wound, the service discussed the concerns with the Doctor involved in their care and communicated the information to the patient.

The bariatric clinical nurse specialist facilitated follow up for patients at three weeks post-operative and at two years post-operative. We were informed specific follow up was completed for individual needs, for example those with a learning disability or mental health condition. Follow up was also extended over the two years if required, for example, staff facilitated a pre-operative and post-operative monthly group, which received attendance from 20 plus patients. The service also signposted patients onto support groups when required.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. During our inspection the surgical services managed to keep men and women separate with all surgical ward bays designated as either male or female. Additionally, there was access to separate male and female toilet facilities.

Facilities and premises were appropriate for the services being delivered. The surgical services were appropriate for the local population and were person centred to meet patient needs. In some areas quiet rooms were available for privacy and to support patients or relatives who became overwhelmed.

Around the trust food and drink facilities were available for patients and relatives. Facilities were located nearby where relatives of patients could purchase hot and cold food and drinks, this included the hospital shop and cafeterias. Patients were also offered food and drink throughout their care and treatment.

The service provided information to patients in accessible formats, including information about their appointments and surgical procedures including contact details both preoperatively and postoperatively.

The service had limited parking facilities for patients and relatives, however, public transport was available through a bus service and the underground. The underground station was in close proximity to the hospital, and bus stops were nearby.

We also found that while recovery bays sometimes had paediatric recovery patients, there was no sensory illustrations displayed responsive to children needs. However, following our inspection we were informed the service contacted their curtain contractors but they did not supply disposable paediatric curtains, therefore the service have asked the recovery team to identify a space to recover children and they plan to commission the painting of a wall mural via the Toy Project.

Staff could access emergency mental health support 24 hours a day, 7 days a week for patients with mental health conditions, learning disabilities and dementia. Staff reported good out of hours support from the site team. Staff we spoke with confirmed who the trust mental health and learning disability leads were and they could access them for support, guidance or referral information. Specialist staff attended patient meetings to ensure multidisciplinary input. For example, staff told us of an elderly patient with mental health needs who had been diagnosed with cancer and was refusing treatment. A best interest meeting was held with attendance from the patient advocate, cancer specialist, breast surgeon and safeguarding lead. We were informed as the patient had capacity to make their own decisions, the patients wishes to refuse treatment were followed. The patient was informed their appointment would be an open appointment if they changed their mind in the future.

The service had systems to help care for patients in need of additional support or specialist intervention. The surgical wards received support from the frailty team when required.

Support was also in place to aid the delivery of care to patients in need of additional support. Bariatric nurses developed patient approaches to meet the needs of bariatric patients. The service also ensured individual support was provided for a patient requiring joint replacement, who had no permanent residency. Specialist support was provided to care for the patient both preoperatively and postoperatively.

Managers monitored and took action to minimise missed appointments. Managers ensured that patients who did not attend appointments were contacted. Staff reported they contacted patients on more than one occasion. For example, when patients were required for a follow up appointment.

The service relieved pressure on other departments when they could treat patients in a day. Staff from different disciplines worked together to care for patients.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff mostly made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. Staff could access speciality leads to receive advice and guidance to enable them to best support patients with mental health needs or learning disabilities. Staff reported they received training in these areas which provided them with awareness and understanding of patient care. Staff helped patients with communication, advocacy and cultural support. Staff we spoke with reported they planned for patients with complex care needs and adapted care to support them. For example, they rephrased information and confirmed patients understood their care and treatment plan.

The pre-assessment service supported the requirement of identifying people's individual needs through a comprehensive health questionnaire completed by nurses with patients, providing the opportunity to discuss and identify specific needs. This included detailed information about allergies including latex and any medicines. Specific patient needs were documents on the electronic system, to inform and alert staff.

Wards were not designed to meet the needs of patients living with dementia. We did not see any distraction aids for simple stimulation activity across any wards, and staff did not report using forget me not information at the side of patient beds. However the service planned to make an area on Coyle ward dedicated to patients living with dementia. The plans were agreed and were financed by charity funds. Staff hoped the dementia friendly area would be in place by end of December 2019. The plans included wall imagery, and seating areas.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. Staff we spoke with confirmed the use of 'This is me' documents to support patients and followed their patient pathway. We also saw the use of a carers passports to inform staff of patients who had a carer and who they were. The carers passport also extended visiting hours.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff received training to support patients with communication needs. During conversations with patients staff rephrased words and spoke at a louder volume to ensure patients understood them. Staff met patient communication needs well and consistently confirmed what they had interpreted.

The service had information leaflets available in languages spoken by the patients and local community. Staff we spoke with reported they could easily access leaflets in alternative languages through the trust intranet. They did not report having any concerns with providing leaflets in languages spoken by patients.

Managers made sure staff, patients, loved ones and carers could get help from interpreters or signers when needed. Staff reported they accessed face to face interpreters when required. We were also informed about a technical device used during out of hours, for interpreting services. Staff who covered day shifts were aware of this device despite reporting they had never required it.

Patients were given a choice of food and drink to meet their cultural and religious preferences. The menus offered a variety of choices to meet patient preference. Patients we spoke with confirmed they were offered a choice of food and drink.

Staff had access to communication aids to help patients become partners in their care and treatment. Staff and patients we spoke with reported the use of illustrations to ensure patient understanding and involvement in their care.

Access and flow

People could access the service when they needed it and received the right care promptly. Waiting times from referral to treatment and arrangements to admit, treat and discharge patients were in line with national standards.

Average length of stay

Managers monitored waiting times and made sure patients could access services when needed and received treatment within agreed timeframes and national targets.

Managers monitored waiting times and made sure patients could access emergency services when needed and received treatment within agreed timeframes and national targets.

Managers and staff worked to make sure patients did not stay longer than they needed to. The service had a thorough discharge process and staff ensured patients were discharged with the correct information at an appropriate time. Staff worked hard to make sure complex discharges were appropriately reviewed and completed for Thursday discharge. This ensured specialist measures were in place for patients before the weekend.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. The trust had a bed management and transfer policy which documented bed allocations and the admission and transfer of patients were coordinated through the clinical bed/site management team. Managers worked to minimise the number of surgical patients on non-surgical wards.

Whittington Hospital – elective patients

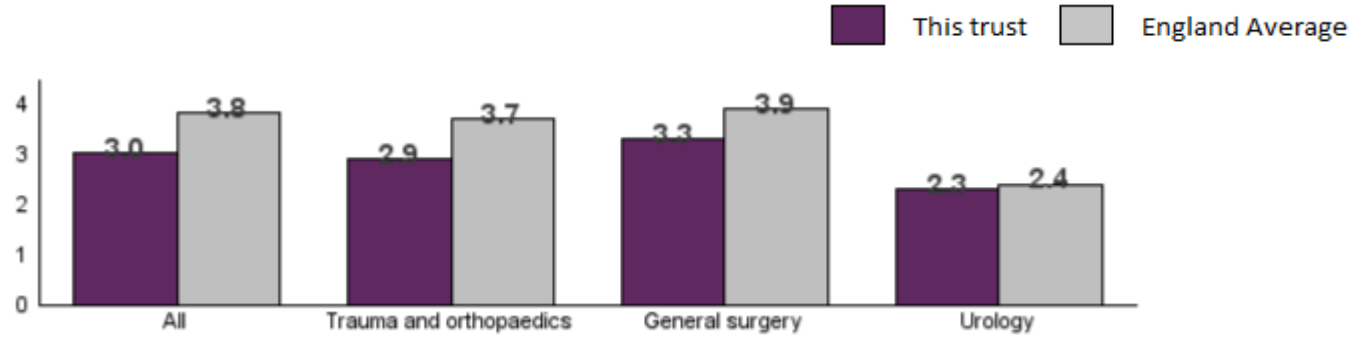
From July 2018 to June 2019 the average length of stay for patients having elective surgery at Whittington Hospital was 3.0 days. The average for England was 3.8 days.

The average length of stay for patients having elective trauma and orthopaedics surgery at this hospital was 2.9 days. The average for England was 3.7 days.

The average length of stay for patients having elective general surgery at this hospital was 3.3 days. The average for England was 3.9 days.

The average length of stay for patients having elective urology surgery at this hospital was 2.3 days. The average for England was 2.4 days.

Elective Average Length of Stay – Whittington Hospital



Note: Top three specialties for specific trust based on count of activity.

Whittington Hospital – non-elective patients

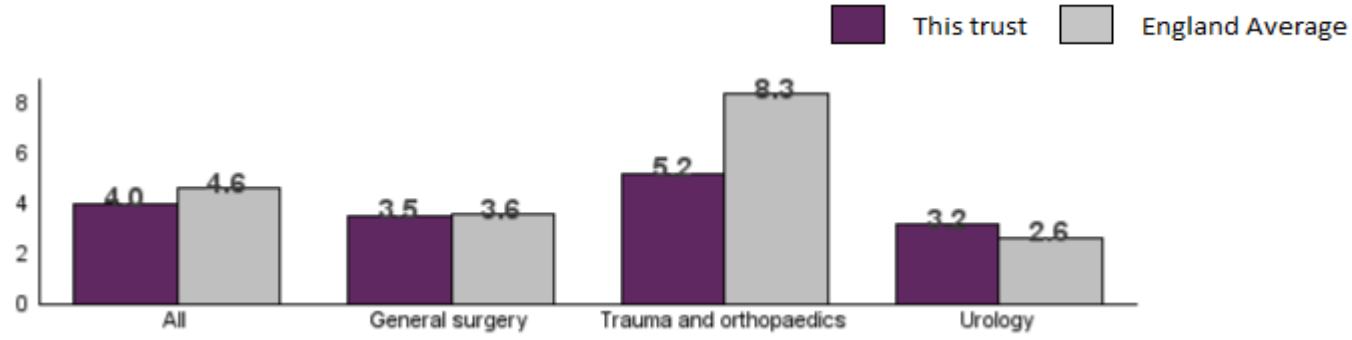
The average length of stay for patients having non-elective surgery at Whittington Hospital was 4.0 days. The average for England was 4.6 days.

The average length of stay for patients having non-elective general surgery at this hospital was 3.5 days. The average for England was 3.6 days.

The average length of stay for patients having non-elective trauma and orthopaedics surgery at this hospital was 5.2 days. The average for England was 8.3 days.

The average length of stay for patients having non-elective urology surgery at this hospital was 3.2 days. The average for England was 2.6 days.

Non-Elective Average Length of Stay – Whittington Hospital



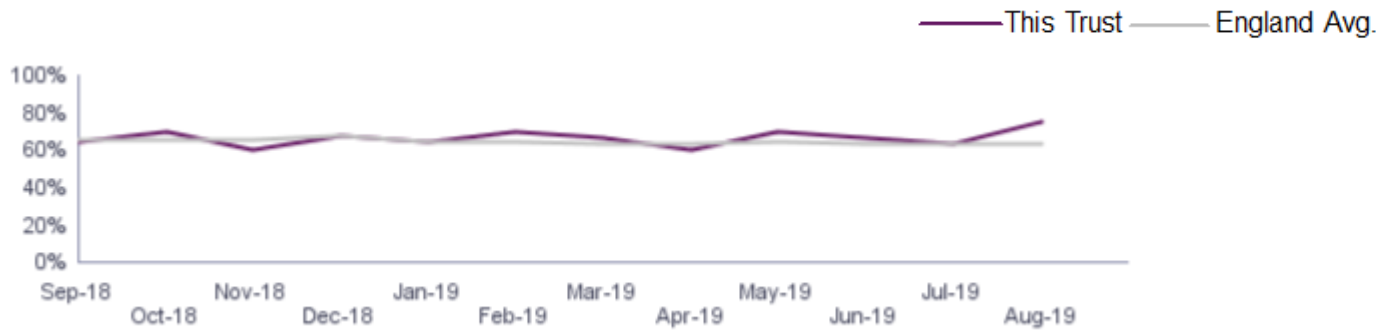
Note: Top three specialties for specific trust based on count of activity.

(Source: Hospital Episode Statistics)

Referral to treatment (percentage within 18 weeks) - admitted performance

From September 2018 to August 2019 the trust's referral to treatment time (RTT) for admitted pathways for surgery was generally about the same as the England average. In the most recent

month (August 2019) the trust's performance improved to 75% which was 11.5% better than the England average.



(Source: NHS England)

Referral to treatment (percentage within 18 weeks) – by specialty

Two specialties were above the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
Urology	79.3%	74.6%
Trauma & orthopaedics	62.5%	58.1%

One specialty was below the England average for RTT rates (percentage within 18 weeks) for admitted pathways within surgery.

Specialty grouping	Result	England average
General surgery	61.1%	72.0%

Cancelled operations

Managers worked to keep the number of cancelled operations to a minimum. Managers we spoke with reported not having many cancellations due to the limited number of beds. They told us the clinical director and operational director would review the operations after December 19 and if cancellations were a possibility they would compile a list. We were informed cancer patients were a priority and patients who had a dietary preparation for a period of time, patients who had previously been cancelled were also reviewed. For the trauma list, the service had facilities for emergency theatre, however, this was not available every day.

Managers, the anaesthetist and senior nurse discussed lists. Staff cannot cancel operations without the associate director of nursing, clinical director and operational director agreement. We were informed the triumvirate had knowledge on wards. Managers reported most elective surgery was day care and therefore prior to cancelling an operation staff were able to contact the consultant for patient history. The consultant reported on the patient's well-being and the emotional impact the cancellation could have on the patient.

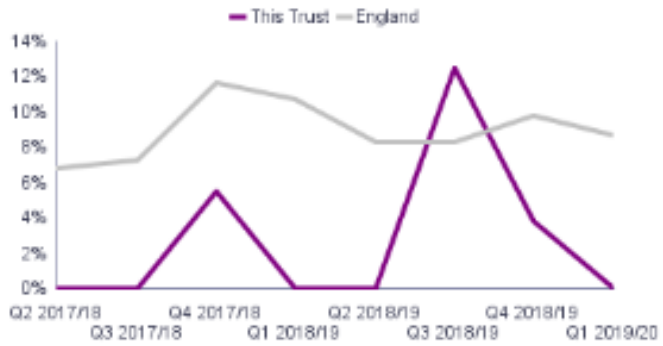
Within pre-assessment mangers informed us cancellations were mostly due to patients with diabetes not controlling their insulin as recommended, this was identified through high blood pressure. Patients sometimes had their surgery deferred, for example, a patient had a pace maker fitted and therefore could not undergo their procedure. Staff reported the patient and the General Practitioner (GP) were informed of the reason for the deferred surgery.

When patients had their operations cancelled at the last minute, managers made sure they were rearranged as soon as possible and mostly within national targets and guidance. The percentage of patients whose operations were cancelled and not treated within 28 days, is mostly below the England average, as demonstrated in the below table.

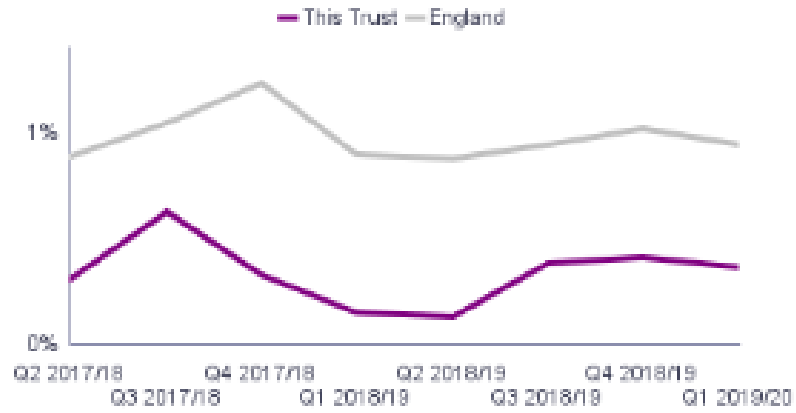
A last-minute cancellation is a cancellation for non-clinical reasons on the day the patient was due to arrive, after they have arrived in hospital or on the day of their operation. If a patient has not been treated within 28 days of a last-minute cancellation, then this is recorded as a breach of the standard and the patient should be offered treatment at the time and hospital of their choice.

The service looked at the number of same day elective cancellations, and how they could reduce the number. Managers identified the main reasons during November and December 2018 and implemented a specific intervention in pre-operative assessment clinic to reduce the same day cancellations.

Percentage of patients whose operation was cancelled and were not treated within 28 days - Whittington Health NHS Trust



Cancelled Operations as a percentage of elective admissions - Whittington Health NHS Trust



From July 2017 to June 2019, the percentage of cancelled operations at the trust was consistently below the England average. Cancelled operations as a percentage of elective admissions only includes short notice cancellations.

(Source: NHS England)

Managers monitored that patient moves between wards were kept to a minimum.

The service moved patients only when there was a clear medical reason or in their best interest. For example, staff reported any medical patients under the endoscopy team were moved to the correct speciality.

Staff moved patients between wards at night.

Patients moving wards at night
From September 2018 to August 2019 there were 276 patients moving wards at night within surgery. The highest number of ward moves at night were from the day treatment centre (112 moves) and Coyle ward (77 moves).

(Source: Routine Provider Information Request (RPIR) – Moves at night tab)

Managers and staff worked to make sure they started discharge planning as early as possible. The service had a flow liaison officer, who was part of the discharge planning team and facilitated the discharges. Discharge meetings were at 10am and included the matron, head of discharge, a band 6 and integrated care, who were community based. Discharge discussions included multidisciplinary teams of specialists involved in patient care, patients and relatives were included in discharge planning and decisions around it. Staff ensured to signpost patients onto other service and completed treatment and care plans to support patients in their recovery.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Ward discharges were daily before 11am, there were posters displayed informing patients and relatives of the discharge time and why. For example, following discharge patients were home by lunch time and they could access other services including shops and pharmacies during opening hours.

Managers informed us complex discharges were planned to include care packages and transport if required. Complex discharges were planned for Thursdays, this ensured any delay was addressed, everything was reviewed and in place for a discharge at the latest Friday before 12pm.

Discharges included input from relevant specialists involved in patient care, for example, occupation therapists (OT), physiotherapists (PT), the discharge planning team, the patient care agency, and community teams if required. Discharge posters were displayed around the wards and included detail of the discharge protocol for total knee replacements and the discharge protocol for total hip replacements.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. A ward clerk we spoke with was also aware of the delayed discharges on their ward reporting they did not have many.

Staff supported patients when they were referred or transferred between services. Specialist input for patient care was included in transferring between services, for example, critical care outreach team supported bariatric patients.

Managers monitored patient transfers and followed national standards.

Patients moving wards per admission
From September 2018 to August 2019 43% of surgical patients moved wards once or more during their admission.

(Source: Routine Provider Information Request (RPIR) – Ward moves tab)

Learning from complaints and concerns

It was not always easy for people to give feedback and raise concerns about care received.

The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Most patients, relatives and carers did not know how to complain or raise concerns. Most patients we spoke with were not aware of how to make a complaint and did not report receiving any information about how to make a complaint. However, most patients told us they did not have any concerns to raise, and were complimentary of the care and service they received. Patients we spoke with also informed us they felt confident to find out how to make a complaint, if required.

The service clearly displayed information about how to raise a concern in patient areas. Posters were displayed on wards titled, “Tell us what you think” which included details on asking the nursing team for more information, help from Patient Advice Liaison Service (PALS), and making a complaint. Individual PALS posters were also displayed around the surgical wards. Information was also displayed on previous complaints to inform patients on any themes identified and actions taken following them.

Staff understood the policy on complaints and knew how to handle them. Staff we spoke with demonstrated the policy they would follow to handle complaints appropriately. Staff knew how and who to escalate complaints to in order to manage them at a local level. Staff were aware of being transparent with patients and informed them of how to make a formal complaint when required. Staff ensured people who raised concerns or complaints were protected from discrimination, harassment or any disadvantage.

Managers investigated complaints and identified themes. The Matron informed us complaints were under the Associate Director, they were confidentially reviewed and allocated to the ward managers to complete a timely response. Complaint were handled in a way which ensured openness and transparency, whilst respecting patient confidentiality. We were informed key themes included communication, discharge specifically patients reported it felt rushed. Managers reported complaints were responded to within good timescales.

Summary of complaints

Trust level

From August 2018 to July 2019 the trust received 22 complaints in relation to surgery at the trust (7% of total complaints received). The trust took an average of 33.4 days to investigate and close complaints. This was not in line with their complaints policy, which states non-complex complaints should be closed within 25 days. A breakdown of complaints by type is shown below:

Type of complaint	Number of complaints	Percentage of total
Inadequate treatment provided	3	13.6%
Poor treatment provided	3	13.6%
Lack of information to relatives	2	9.1%
Poor standard of care provided	2	9.1%
Rudeness/disrespectful	2	9.1%
Sharp/harsh/abrupt	2	9.1%
Clarity/confusing	1	4.5%
Delays in medication being administered	1	4.5%
End of life care	1	4.5%

Failure to follow prescribed care	1	4.5%
Inadequate communication about an operation	1	4.5%
Inappropriate behaviour	1	4.5%
Incorrect treatment provided	1	4.5%
Poor pain control	1	4.5%
Total	**22**	**100.0%**

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Number of compliments made to the trust
From August 2018 to July 2019 there were 46 compliments received for surgery at the trust (12.6% of all received trust-wide).

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Staff we spoke with, escalated concerns to managers and would receive updates of the result.

Managers shared feedback from complaints with staff and learning was used to improve the service. Wards displayed details of the top three complaints to inform staff, for example, on Coyle ward, the top three complaints displayed were the quality of food, noise from visitors at night and the delays to patients receiving their TTA medication. Staff we spoke with also told us they received emails informing them of complaints and lessons learned were shared.

One ward manager informed us of a complaint they received last month regarding a patient requiring a bed pan during the night. The manager informed us they investigated the complaint and at the time a cardiac arrest was in progress.

Is the service well-led?

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

Managers at all levels in the trust had the right skills and abilities to run a service providing high-quality sustainable care. The leadership team for surgery was shared with critical care, it included the clinical director, associate director of nursing, and the operational director. Supported by specialism heads of service, matrons and ward managers. The range of experience within the senior team enabled effective leadership of the surgical service.

Staff told us they felt local managers were visible, approachable, supportive and they received appropriate support to allow them to complete their jobs effectively. For example, during our inspection we observed the associate head of nursing visiting a ward, staff we spoke with confirmed they were often visible on the ward and approachable for questions or concerns.

We were also informed the finance director occasionally spent the morning on a ward, and both the chief executive and chief nurse were a massive presence on the surgical services.

We found the leaders at a local level were also visible and approachable and staff we spoke with confirmed they contacted ward managers or the matron for support. Managers had a good oversight of the service and understood the challenges to quality and sustainability and they identified actions needed to address them. For example, managers were aware of staff mandatory training compliance and were putting in actions in place to increase training figures.

Leadership at consultant level was positive, for example, junior staff were well supported.

Staff across surgical services were encouraged to increase their skills and were supported to take on more senior roles. For example, the ward manager on Mercers ward informed us they looked at ways staff could develop into progressive roles at the point of recruitment. Retention of staff was a focus as well as recruitment.

Vision and strategy

The service had a strategy, developed with all relevant stakeholders. The strategy was focused on sustainability of services and aligned to local plans within the wider health economy. However, the service did not have a clear vision and staff did not understand or know how to apply the strategy and monitor progress.

The trust vision “helping local people live longer, healthier lives” was displayed on posters throughout the surgical services. Along with the trust’s four key objectives to achieve their vision from 2019 to 2024. The trust objectives: deliver outstanding safe, compassionate care; empower, support and develop staff; integrate care with partners and promote health and wellbeing; and transform and deliver innovative, financially sustainable services.

The leadership team reported they had a high-level strategy, which was part of the surgery business plan to address the trust objectives. They reported the strategy was in line with the trust objectives to provide outstanding and safe care. The leadership team facilitated an away day in the summer 2019 which provided staff with an understanding and included their involvement of where the service was going. The service informed us they planned to look at how they will deliver the objective in the new year (2020), which will include group sessions of comparing practice against the objectives.

Some staff we spoke with were aware of the vision and strategy of the trust, however, they were not aware of any surgery specific strategy, and therefore we were not assured staff had involvement in achieving the vision, values or strategy.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff felt respected supported and valued. They confirmed they felt comfortable to approach managers if they had any concerns which needed addressing. Across surgical services we found a shared culture which centred on the needs and experience of people who used the service. This positive culture created a sense of common purpose, for staff, based on shared values. Staff demonstrated positive relationships with patients and their relatives.

Staff at all levels in all roles were positive and felt proud to work for the organisation, with members of staff reporting they “love it here”. Staff we spoke were aware of duty of candour and described the service as being transparent, open and honest. Managers we spoke with operated an open-door policy and felt staff came to them without fear of retribution.

Equality and diversity was promoted within and beyond the organisation as all staff, including those with particular protected characteristics under the Equality Act, felt they were treated equitably. For example, one member of staff reported they were very happy, loved their job, and felt supported within it. One member of staff reported that everyone was a family on the ward.

Mechanisms were in place to provide staff with the development they needed. Staff told us they were supported to develop within their role, and progression was encouraged. However, not all staff had received their appraisal, managers were aware of this, and reported they supported staff informally as and when required.

We found services to have an emphasis on the safety and well-being of staff. For example, one ward manager had returned to work following a back injury, they were taken off clinical duties as part of their recovery process.

The service took appropriate action to address behaviour and performance that was inconsistent with the Trust vision and values, regardless of seniority.

Our inspection found staff and teams worked collaboratively across specialisms, and effective multidisciplinary working was evident. Surgical services shared responsibility and resolved conflict quickly and constructively.

Governance

Leaders did not always operate effective governance processes, throughout the service and with partner organisations. However, staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

We found leaders did not consistently have effective governance processes in place to support the delivery of good quality, sustainable services. For example, there is the requirement to carryout daily cleaning tasks in the anaesthesia room, prior to start of anaesthesia in the morning and or in the afternoon. Records contained in the purple folders located in each anaesthesia room, displayed gaps and therefore absence of evidence resulting in poor compliance for daily cleaning checks. We were not assured of the rigour of the clinical governance process by senior staff, as this poor compliance had not been identified.

The service did not follow AAGBI guidelines for daily checks of essential clinical equipment in theatres such as the Anaesthesia Machines. The guideline states this task must be signed for daily and prior to the start of a theatre list. We looked at log books in three surgical theatres and found there were several gaps and blank dates with no signatures. We were not assured appropriate governance processes were in place to ensure this standard was met.

The matron informed us they previously completed ‘back to floor’ days where they undertook staff duties to be a part of current practice on the ward. This could have enabled managers to have an increased oversight of clinical processes.

The levels of governance and management did not always function effectively and appropriately interact with each other. For example, the communication process was effective up to the board level and cascaded down to staff through monthly matrons and ward manager meetings. However, staff reported governance was not being appropriately discussed. We were informed governance was part of the surgical board meeting, however managers identified there was too much content to cover and two meetings are now held, one for governance and one for operational content.

Managers reported they wanted to ensure the process was consistent with the trust governance, and therefore only one meeting, November 2019, had taken place at the time of our inspection. This aligned with staff response to management of governance.

All staff we spoke with at all levels, were aware of their roles and responsibilities, who they reported and what they were accountable for.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had effective systems for identifying risks, planning to eliminate or reduce them, and coping with both the expected and unexpected. Monthly meetings were held with the Directors of Surgery and Cancer and the Quality and Risk Manager to monitor and update risks.

The risk register was held by the division. It was electronic and in place for recording and managing risks. The risk register included a description of each risk, initial risk rating and current risk rating, the owner and actions taken. The leadership team informed us, previously there was no governance around risks previously and now they keep an audit trail of the risks.

Staff were supported to add new risks to the register, they received training on awareness of risk criteria and rating. New risks added to the register were signed off by the clinical director, associate director of nursing, and the operational director.

The leadership team informed us of the following risks: Financial balance; anaesthetic cover; adequate establishment to provide services; and locum roles to convert to substantive roles.

In theatres, risks displayed on the information board for staff included, the bleep system, sharps disposal and staff skill mix.

We were informed of the concerns around the bleep system, which included persistent areas where bleeps did not go off, managers reported this was in discussion with facilities. Mitigation put in, staff have been auditing how effective it is, and found it is still variable. The leadership team informed us the Chief Operating Officer (COO) was aware and no patient harm had been reported, however, managers told us it was causing stress for staff, in regard of getting hold of someone. The leadership team informed us they reviewed the risk and increased the risk rating.

At ward level, risks were discussed at the monthly matron and ward manager meeting. New risks were discussed including serious incidents and reported to the leadership team.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

At local and management levels there was holistic understanding of performance. We found monthly performance data was collated and mostly cascaded down to staff at local levels.

The trust collected, analysed, managed and used information well to support all its activities using secure systems with security safeguards.

We saw robust arrangements to ensure the availability, integrity, and confidentiality of identifiable data, records and data management systems were in line with data security standards. This was evident with the use of lockable cabinets and locked computer stations. The records we reviewed were legible, completed thoroughly and were up to date. At the end of patient beds paper records were of care reported and did not include medical records.

Service performance measures were reported and monitored. The matrons and ward managers had access to a quality and safety figures, which displayed performance measures. The information was displayed on the monthly Ward Clinical Quality Indicators report. This meant staff could see how well wards were performing.

Patient outcomes were measured across surgical services. The outcomes were provided to managers to review and update staff with any areas for improvement.

Data or notifications were consistently submitted to external organisations, for example the care quality commission, as required.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust engaged well with patients, staff, the public and local organisations to plan and manage appropriate services, and collaborated with partner organisations effectively. People's views were gathered and acted on to shape the and improve the services and culture. For example, the service planned to move all elective joint procedures to a local NHS trust, in response to patient and public contribution.

The leadership team informed us of the new governance meeting which initiated last month (November 2019). Managers reported engagement was vital, and the feedback they received was positive in aiding decisions of the process. For example, following engagement patient stories were used, and changes from audits were to be presented. The meetings were held once monthly and including attendance from the clinical lead, and matrons who were to cascade to teams.

Surgical wards and operating theatres held team meetings, and staff took notes so they could be shared with staff who could not attend. These provided relevant updates about the division and the wider trust. A staff huddle took place each day for sharing and learning purposes. Staff spoke positively of being involved in decisions and new ways of working.

Most staff we spoke with were involved in the way services ran and could openly share ideas to managers to help improve services for patients. For example, staff recognised areas in their own development where they could increase skills and knowledge. Staff requested training and as a result provided better care for patients.

The surgical services provided transparency and openness with stakeholders about performance. Some performance data was available in the public domain.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The trust was committed to improving services by learning from when things went well and when they went wrong, promoting training, research and innovation.

The surgical and cancer services shared a quarterly newsletter, which informed staff of updates and encouraged them to contribute information. In May 2019 Coyle ward were awarded 'ward of the year', this recognition was documented in the newsletter.

Mortality and Morbidity reviews were discussed at the matron and ward managers monthly meetings. Staff informed us they learnt from the information discussed and reflected on the impact the reviews had to their service, to improve patient care.

The service had systems to support improvement and innovation work including objectives and rewards for staff. For example, the surgical services had a staff recognition scheme, called the Frog award. Staff could nominate each other and provide details of their nomination to the matron. The Frog awards took place three times per year and included a presentation following the ward manager and matron monthly meeting. We were informed the most recent Frog scheme had 50 nominations with two winners. The winners received a post code with a picture of a frog on it, and a cup cake. Staff we spoke with were appreciative of this award as it gave them recognition of their work and encouraged commitment in improving services.

The service demonstrated learning and improvement through information received from the Clinical Commissioning Group (CCG) regarding communication between surgical teams. Following the concerns mangers recognised an area for improvement for all staff and used the dedicated handover period on Friday afternoons to provide training in the identified area of improvement for staff at all levels including trainees and consultants. Staff reported positive feedback following this session.

As part of the quality and improvement project, the service planned to install a red stripe on the wall above Call bells in anaesthetic and recovery rooms, main theatres and DTC. Facilities (FES) were on board for the work, and managers hoped it should help to achieve better visualisation of call bells in an emergency following on from difficulties with main theatres call bells. The service reported this as an addition to safety, and to ensure staff follow a simple process in an emergency.

On one ward, the manager informed us of innovation to recruit staff, for example, instead of recruiting band 5 nurses, with the same budget they recruited, three band 4s and two band 6 registered nurses. The band 6s work alongside and support the band 4s.

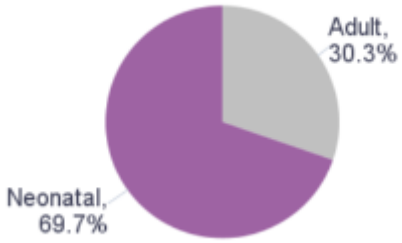
Critical care

Facts and data about this service

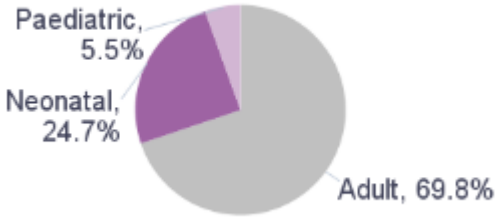
The trust has 33 critical care beds. A breakdown of these beds by type is below.

Breakdown of critical care beds by type, Whittington Health NHS Trust and England

This trust



England



(Source: NHS England)

Whittington Hospital has one general critical care ward, consisting usually of ten critical care beds (the service could increase their capacity to 14 beds if needed, with appropriate staffing). The ward was located on the second floor of the hospital, adjacent to surgical theatres.

The critical care service is designed to accommodate patients with level two (high dependency) and level three (intensive care) needs and could manage a maximum of 11 level three patients at any one time. Level two care describes patients requiring more detailed observation or intervention. This includes support for a single failing organ system or post-operative care, and those 'stepping down' from level three care. Level three care refers to patients requiring advanced respiratory support alone, or monitoring and support for two or more organ systems. This level includes all complex patients requiring support for multiple organ failure.

Critical care ward came under the Integrated Clinical Service Unit (ICSU) for Surgery and Cancer. There is a neonatal intensive care unit managed by the Children and Young People (CYP) ICSU, which provides intensive care and critical care baby cots and operates at level two. We did not inspect the neonatal intensive care unit as part of this inspection as this does not form part of the critical care core service.
The hospital had a nurse led critical care outreach team (CCOT) to support the needs of acute and deteriorating patients on surgical and medical wards.

The critical care provision was led by a group of general intensivists. The nursing provision consisted of general ICU nurses and healthcare assistants. The critical care ward also had access to physiotherapists, speech therapists, dieticians, and pharmacy support.

As at August 2019 there were 46.9 nursing whole time equivalents (WTE) and 5.6 medical WTE working in this service.

Source: Routine Provider Information Request (RPIR)

We visited the critical care ward over three days during our announced inspection on the 3 December to 5 December 2019.

We reviewed six patient care records and observed care being provided. We spoke with six relatives and carers, four patients and 19 members of staff including nurses, consultants, junior doctors, physiotherapists, pharmacists, dietitians, and administrative staff. We also reviewed the trust's performance data and looked at trust policies for critical care.

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.
*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The service provided mandatory training in key skills to all staff, however medical staff were not meeting the trust target of 90% for completion of mandatory training.

The trust set a target of 90% for completion of mandatory training.

Mandatory training modules were a mix of classroom delivered training and e-learning. Staff were able to access and complete training modules remotely if needed.

Managers monitored mandatory training and alerted staff when they needed to update their training. Staff completion of mandatory training modules was monitored by managers through the trust training system. Staff were informed when training was due to expire, and they were expected to book on to the next available training.

A breakdown of compliance for mandatory training courses as at 31 August 2019 at Whittington Hospital for qualified nursing staff in critical care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Infection prevention and control	53	54	98.1%	90%	Yes
Fire safety	52	54	96.3%	90%	Yes
Health and safety	51	54	94.4%	90%	Yes
Risk management / duty of candour	51	54	94.4%	90%	Yes
Equality and diversity	50	54	92.6%	90%	Yes
Moving and handling	50	54	92.6%	90%	Yes
Information governance	49	54	90.7%	90%	Yes
Conflict resolution	48	54	88.9%	90%	No

Resuscitation	48	54	88.9%	90%	No

Nursing staff received and kept up to date with their mandatory training. In critical care the 90% target was met for seven of the nine mandatory training modules for which qualified nursing staff were eligible. Two modules, conflict resolution and resuscitation, missed the 90% target by 1.1%.

A breakdown of compliance for mandatory training courses as at 31 August 2019 at Whittington Hospital for medical staff in critical care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Resuscitation	13	17	76.5%	90%	No
Risk management / duty of candour	13	17	76.5%	90%	No
Equality and diversity	12	17	70.6%	90%	No
Information governance	12	17	70.6%	90%	No
Health and safety	11	17	64.7%	90%	No
Moving and handling	10	17	58.8%	90%	No
Fire safety	9	17	52.9%	90%	No
Infection prevention and control	9	17	52.9%	90%	No
Conflict resolution	8	17	47.1%	90%	No

In critical care the 90% target was not met for any of the nine mandatory training modules for which medical staff were eligible. The lowest training completion rate was 47.1% in conflict resolution which equated to nine out of 17 medical staff not completing the training. The divisional leadership for critical care recognised this as an issue and stated that training had improved since the data was provided.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

The trust set a target of 90% for completion of safeguarding training.

Nursing staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses as at 31 August 2019 at Whittington Hospital for qualified nursing staff in critical care is shown below:

Training module name	August 2019				

	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	54	54	100.0%	90%	Yes
Safeguarding adults level 2	51	54	94.4%	90%	Yes
Safeguarding children level 2	44	53	83.0%	90%	No
Safeguarding children level 3	0	1	0.0%	90%	No

In critical care the 90% target was met for two of the four safeguarding training modules for which qualified nursing staff were eligible. There was 0% training completion for the safeguarding children level 3 module, however only one member of staff was eligible for this training.

Medical staff received training specific for their role on how to recognise and report abuse. A breakdown of compliance for safeguarding training courses as at 31 August 2019 at Whittington Hospital for medical staff in critical care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	17	17	100.0%	90%	Yes
Safeguarding adults level 2	9	17	52.9%	90%	No
Safeguarding children level 2	6	17	35.3%	90%	No

In critical care the 90% target was met for one of the three safeguarding training modules for which medical staff were eligible. Safeguarding children level 2 training was completed by 35.3% of staff which equated to 11 members out of 17 of staff not completing the training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Staff knew how to identify adults and children at risk of, or suffering, significant harm, and worked with other agencies to protect them. Staff had a good understanding of when they would need to report safeguarding issues and who they would contact if they had any concerns. The ward did not have a safeguarding lead at the time of inspection, however all staff were aware of the trust safeguarding lead, and the safeguarding team had their office located next door to critical care. There were also posters up in the main ward area displaying contact details for the safeguarding team.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. All safeguarding referrals were sent to the adult safeguarding team and could then be forwarded to the local authority of the relevant borough for investigation. The safeguarding forms and website pages contained contact details for the trust safeguarding team, and for local authorities in the North London area.

We reviewed the hospital safeguarding policy, which detailed what to do in the event of a safeguarding concern and reflected the service's obligations under safeguarding legislation. Staff

were also able to provide examples of when they had to contact the safeguarding team or completed safeguarding referrals, and we found these examples complied with the safeguarding policy.

Staff we spoke with were aware of specific safeguarding risks to patients, such as female genital mutilation (FGM) and domestic violence (DV), and would identify these issues to the safeguarding team. However divisional staff stated that FGM was not included in safeguarding training, or as an individual mandatory training module.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean. However there was inconsistent use of monitoring for when equipment was cleaned, and staff did not use personal protective equipment (PPE) consistently.

Ward areas were clean and had suitable furnishings which were clean and well-maintained. The main critical care areas we checked were generally clean with minimal clutter in corridors or clinical areas. The area outside the isolation rooms (which were only used in certain circumstances) was being used to store some equipment, such as chairs for bariatric patient. Staff recognised they had minimal storage space on the ward.

Staff cleaned equipment after patient contact, however use of labels to show when equipment was last cleaned was inconsistent. The service used ‘I am clean’ stickers to identify equipment that had been cleaned and was ready for use. All the equipment we checked was clean and ready for use, although the use of ‘I am clean’ stickers stating when equipment or areas were cleaned was inconsistent. Equipment was also checked and audited regularly, and the ward assigned a nurse to lead on monitoring compliance for equipment.

We observed consistent staff compliance with infection prevention and control (IPC) best practice guidance in relation to hand hygiene and ‘bare below the elbows’ protocols. Staff in clinical areas were noted to clean their hands between patient interactions, while staff (including non-ward based staff) were also bare below the elbow. Entrances to the ward and clinical areas had hand sanitising gel dispensers. We observed staff and visitors using these on the ward.

However most of the staff we observed were not using personal protective equipment (PPE) while delivering patient care. Staff stated that the trust policy was PPE was only needed if there were expecting to come into contact with bodily fluids and that this had been communicated to staff, however we observed some staff consistently using PPE while others did not. Senior staff for the service recognised this would be inconsistent practice, and that it would follow the matter up with the IPC leads for the trust.

Cleaning records were up to date and demonstrated that all areas were cleaned regularly. Cleaning schedules were used to monitor the completion of daily, weekly, and monthly infection prevention and control tasks. Cleaning was completed by a mix of staff in clinical areas and house staff. We observed these tasks being carried out, such as cleaning of bed areas once a patient had been discharged. Staff on the ward were positive about the quality of cleaning provided by domestic staff.

Waste was separated and disposed of in line with best practice guidance relating to clinical waste and sharps. Staff were informed of local arrangements relating to clinical waste disposal and sharps bins.

The Critical Care Unit (CCU) had a suitable control of substances hazardous to health (COSHH) policy and procedures in place for staff to follow. COSHH risk assessments were undertaken, and the service ensured compliance with COSHH arrangements through monitoring. For example, hazardous substances and materials were kept in secured areas only accessible by staff.

The critical care ward had carried out a number of IPC audits in the last few months, including audits of ventilator associated pneumonia and on management of central venous devices. The nursing quality score card also included indicators for hand hygiene performance and number of patients that may be an infection risk (eg MRSA). However, we did not see evidence of a consistent audit process for monitoring compliance with best practice for IPC. Staff were also unsure if there was an IPC link nurse for the ward, or who monitored IPC performance. Senior staff stated this would be carried out by the trust IPC team, but following inspection we were not provided with evidence of IPC audit programme for critical care.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe.

The critical care provision was provided on the main ward with 10 beds. The ward environment was capable of managing level two and level three patients, and there were four side rooms (off the main ward) which could be used to manage patients in isolation.

The critical care ward environment was generally clean and well maintained. However the floor of the main nursing station area in the critical care ward was impacted by repeated use, and had a lot of indented marks which could present an infection control risk (as it would be difficult to sufficiently clean). Senior staff recognised that this presented a minor risk and were aware of it, but there were no current plans to replace the flooring.

Emergency equipment such as a resuscitation and emergency intubation trollies and crash bags were available. Staff checked resuscitation equipment daily in line with guidance from the Resuscitation Council. We also observed critical care transfer bags in each clinical area which were regularly checked.

Entrances to the critical care ward were controlled by security card, and visitors were required to identify themselves by using the intercom to staff before being granted entry. The front entrance was also manned by administrative staff during working hours. We observed these systems were used consistently.

On inspection we observed that the date of the last electrical testing for some equipment had expired in 2018. Staff stated that this evidence was now maintained electronically by the medical physics team, and any equipment that required servicing was in date. This evidence was provided to us on inspection. Staff stated that where equipment was not working, maintenance was organised quickly to provide repair. Staff also stated the hospital was quick to address any environmental or equipment issues identified.

Patients could reach call bells and staff responded quickly when called. Patients we spoke with confirmed staff answered call bells in a timely manner. Patients reported they had no concerns for staff response even during busier periods they felt staff were very attentive.

The design of the environment followed national guidance. The ward was designed in line with the building regulations for critical care units (HBN 04-02) in 2013. The service showed evidence of consideration of HBN 04-02 as part of the development process, in line with the recommendations of Guidelines for the Provision of Intensive Care Services (GPICS 2015).

Staff carried out daily safety checks of specialist equipment. Since the time of the last inspection, the service had a nominated lead for monitoring the suitability and maintenance of equipment. We saw checks had been carried out on ventilators and other equipment in line with best practice. The trust also provided evidence following inspection of equipment logs, which showed equipment (such as ventilators and syringe drivers) were regularly serviced.

The service had suitable facilities to meet the needs of patients' families. Visitors could access the on-ward family room, or the visiting room located opposite the ward. Each area had information leaflets on services offered by the hospital to support patients and family members. The service also had access to on-site accommodation for family members to stay overnight.

The service had enough suitable equipment to help them to safely care for patients. Critical care equipment such as resuscitation equipment and ventilators were readily available, and staff knew where to access it as needed. Staff also had access to equipment for patients with complex needs such as bariatric chairs and hoists.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and took action to remove or minimise risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify patients at risk of deterioration and escalated them appropriately. Staff used the national early warning scores (NEWS2) system to assess and monitor deterioration in patients, which were kept at the patient bedside. We saw the NEWS form used by staff to monitor any deterioration in the patient's status, and observed staff discussing the NEWS score when deciding on care plans.

Staff knew about and dealt with any specific risk issues. Staff completed risk assessments for each patient on admission and updated them when necessary using recognised tools. Patients were screened on admission and as necessary for sepsis, infection control risks, falls risk, pressure ulcers, and others. We saw consistent evidence of this recorded in patient notes and risk assessment tools in use.

The critical care service had pathways in place for patients at risk of deterioration. Staff we spoke with were aware of the actions taken when there were signs that a patient was deteriorating, and the pathways were posted on notice boards on the ward. This included pathways for sepsis, resuscitation, and anaphylaxis.

The trust used a venous thromboembolism (VTE) risk assessment tool which was completed on

the ward computers. While we saw evidence of patients who have started on pathways to manage their risk of VTE, the staff could not provide documented evidence of the risk assessment for these patients.

Management of sepsis on the critical care ward was in accordance with the hospital's policy on sepsis recognition and management. Staff told us that they followed the United Kingdom sepsis guidance on the management of septic patients, and we saw evidence of screening in patient records we reviewed. The 'Sepsis Six' approach was used, sepsis training was mandatory, and the sepsis pathway was visible on notice boards across critical care environments. Sepsis Six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis. The service had a nominated nurse identified as the sepsis lead for critical care, although at time of inspection this role was vacant.

NEWS monitoring was also used trust wide as necessary to monitor patients at risk of deterioration. Staff on the ward and in A&E had a warning system and escalation flow chart to decide when to make a referral to the critical care outreach team (CCOT). Staff recorded the patient's physiological observations every six hours or more frequently if required.

The CCOT provided an outreach service from 8am to 8:30pm, seven days a week. Overnight cover for critical care was provided by the ward registrar and the night nurse practitioner. Staff we spoke to on the ward told us that the outreach team were very accessible and easy to contact for support.

The CCOT provided regular training and education support to staff on the ward in how to identify high-risk and deteriorating patients. The team used audit data to monitor staff compliance with the escalation process and provided feedback to help improve practice.

Staff told us that if a patient had a cardiac arrest on the unit they would use the hospital's emergency '2222' bleep system to contact the hospital's resuscitation team as well as setting off the emergency alarm to alert all staff on the unit. The clinical manager for the critical care ward was also the trust resuscitation team lead, and performed regular simulation exercises, as well as post-event analysis of responses to emergency calls.

As recommended by NHS England, the service had developed local safety standards for invasive procedures (LocSSIPs). The standards set out the key steps necessary to deliver safe care for patients undergoing invasive procedures, some of which apply to critical care (such as out of theatre intubation, or nasogastric feeding tubes). The trust had appointment implementation leads for LocSSIPs, including for critical care. We saw evidence from clinical governance records to remind staff that the service was now using LocSSIPs, and to be familiar with the new standards of practice.

Any tissue viability concerns could be reported to the hospital tissue viability nurse (TVN) for support and advice, particularly managing any complex pressure ulcers. Staff stated they were able to ask for support in managing pressure ulcers, and staff recognised that pressure ulcer management was an area that critical care was trying to improve. TVNs had also provided some on-ward training in the past to improve skills.

The hospital managed patients coming in through the acute patient intake and post-operative

surgery patients. If patients required specialised critical care (such are neuro or cardiac intensive care) they would be stabilised at the Whittington Hospital and then transferred as soon as clinical appropriate. However, the majority of critical care staff did not have transfer training to manage the transfer of patients, which meant that patients might be transferred by staff without the required training. Following inspection, the trust provided evidence that 16% of staff involved in patient transfers had received the training. The trust stated that the 'Step One' national critical care competencies for all nurses had been introduced two years ago. This included competencies related to inter and intra hospital transfers, and that all nurses employed by the trust in the last two years have completed this (although this is separate from transfer training).

We observed shift changes and handovers while on inspection and found them to include allocation of nurses to patients for the shift. However, the handover did not include much consideration of individual patient risks, complexity of need, or input from multidisciplinary or specialist staff. Critical care also did not include daily safety huddles. Following inspection, the trust stated handover and safety huddles were currently being reviewed by the clinical lead and staff. Senior nursing staff stated they wished to engage with peers across their networks to identify best practice and implement this in critical care.

Nurse staffing

The service had enough nursing staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The table below shows a summary of the nursing staffing metrics in critical care at Whittington Hospital compared to the trust's targets, where applicable:

	Critical care annual staffing metrics						
	September 2018 to August 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	12%	3.5%			
All staff	70.6	6%	15%	18.1%			
Qualified nurses	48.2	0%	18%	23.5%	4,191 (4%)	2,436 (2%)	881 (1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Nursing bank agency tabs)

Nurse staffing rates within critical care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for turnover and bank use. There is not enough variation in the vacancy rates over the last 12 months for qualified nurses to comment on the performance of this metric over time.

Vacancy rates

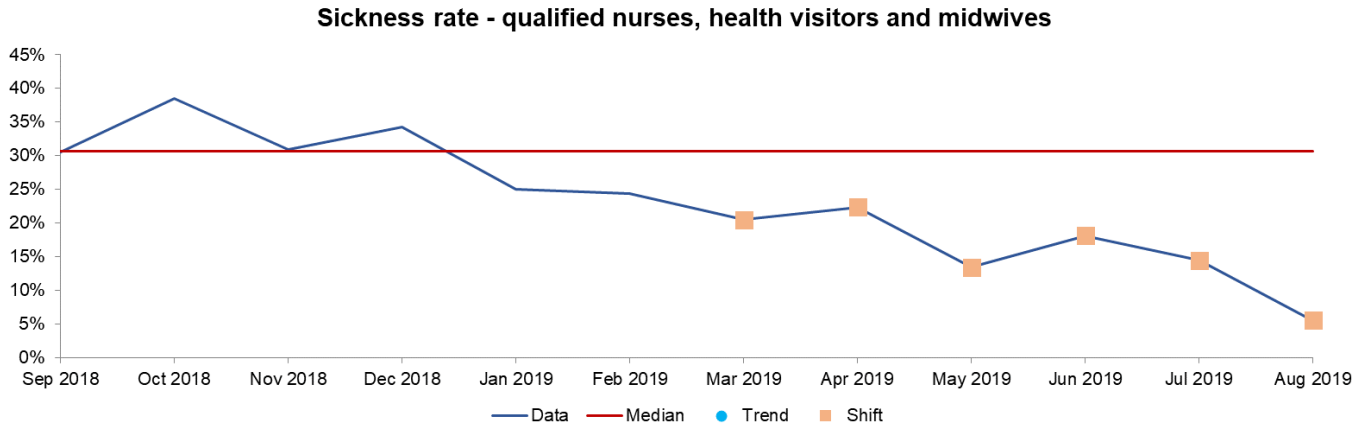
The service had low vacancy rates for nursing staff.

Turnover rates

The service had low turnover rates for nursing staff.

Sickness rates

The service had low sickness rates for nursing staff.

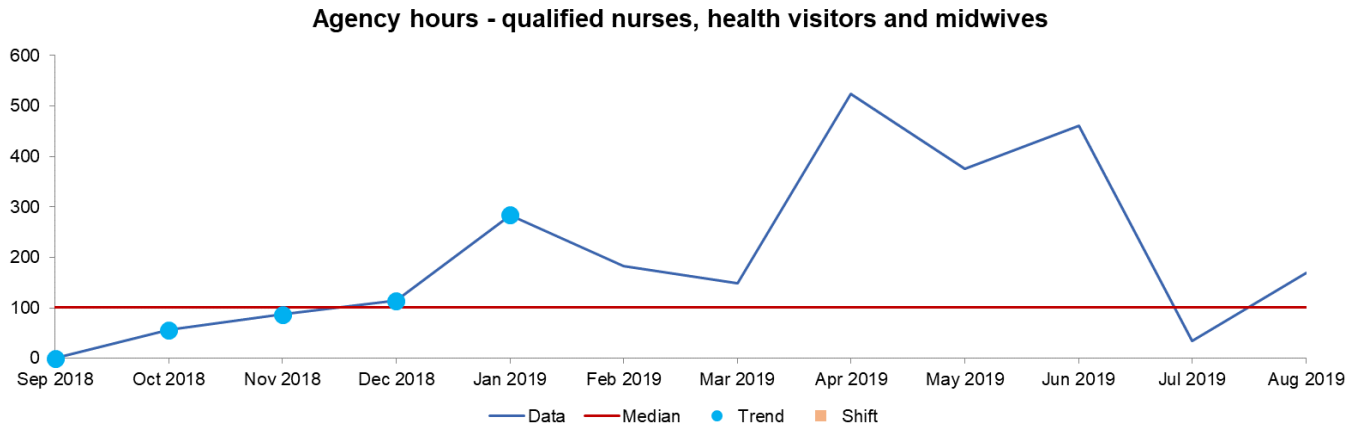


Monthly sickness rates over the last 12 months for qualified nurses show a shift from March 2019 to August 2019.

(Source: Routine Provider Information Request (RPIR) – Sickness tab)

Bank and agency staff usage

The service had low rates of bank and agency nurses.



Monthly agency hours over the last 12 months for qualified nurses show an upward trend from September 2018 to January 2019.

(Source: Routine Provider Information Request (RPIR) - Nursing bank agency tab)

The critical care ward had a staffing acuity tool which it used to decide necessary staffing levels. Nursing leadership and ward staff stated that the ward was generally well staff and they could access additional support if they needed to. Nursing provision in critical care was also reviewed throughout the day, and any concerns on night shifts were escalated to the site nursing lead.

The clinical manager also managed the critical care outreach team (CCOT) and reported into the associate director of nursing (ADON). Staff we spoke with were very positive about the influence and impact of the interim leadership, stating they have had a positive impact on the working environment and culture. However, since the time of the last inspection, there had been significant tension in the nursing team that had impacted the morale and culture of staff and may have impacted on retention of some experienced staff. This issue is covered in more detail in the Well Led domain.

At the time of the inspection, the service did not have a matron. The clinical manager, who was providing interim cover for the matron post, was also responsible for several other roles, both across critical care and hospital wide. This meant they had limited time to spend on the ward and on management duties for critical care. Following the inspection, the trust stated that the clinical manager was fully supported by the divisional leadership and were positive about their impact in the role. The division leadership also stated the nursing leadership will be reviewed following the organisational development work, to ensure clinical manager was able to deliver the role successfully and in line with best practice.

FICM standards for Intensive Care Units state that all level three (patients requiring advanced respiratory support alone or basic respiratory support with support of two other organ systems) patients are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care. For level two (patients requiring more detailed observation and higher levels of care such as those receiving basic respiratory support or with single organ failure) patients a ratio of 1:2 is required. We reviewed patient allocation records and staffing during our inspection which showed the critical care ward complied with the required staffing levels.

We observed on inspection that staff may be involved in delivering support for other patients at times of high activity, meaning that their allocated patient may be left unattended. Although this was for a short period of time, we did not observe nursing staff discussing with colleagues that a patient allocated to them would be left unattended, and that the patient may need some supervision from another member of the nursing team.

FICM Core Standards suggested a minimum of 50% of registered nursing staff should have a post registration award in critical care nursing. Data provided by the trust after the inspection showed that 67% of CCU staff were meeting the criteria for post registration qualifications.

Managers limited their use of bank and agency staff and requested staff familiar with the service. Staff we spoke with stated that the service used bank staff where possible, instead of agency staff, as they would be more familiar with the ward and could deliver more continuity of care. Managers made sure all bank and agency staff had a full induction and understood the service.

The FICM Core Standards recommends no more than 20% agency staff usage per shift. Data provided by the trust showed that agency staff use on the unit had been 6.5% between September 2018 to August 2019 which was compliant with the FICM standard.

Nursing staff worked shifts from 7.30am to 8.00pm and nightshifts from 7.30pm to 8.00am, with handovers taking place between each shift. We attended a nurse handover and found although it included allocation of nurses to patients, it did not include discussion of patient risk or complexity and was not structured. Senior staff we spoke with stated that nursing handovers and huddles were under review.

Nursing staff stated they had regular team meetings to review clinical practice and performance, and to review any arising issues. Senior staff stated that due to recent issues in the critical care team, there had been frequent discussions with staff regarding the culture on the ward, and this meant less focus on clinical practice and governance.

The critical care ward had practice development nurses (PDN) allocated to the unit to support learning and training for staff. The PDNs we spoke to stated they were involved in regular training and support for staff, and critical care staff were positive about the impact of the PDNs.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed staffing levels and skill mix, and gave locum staff a full induction.

The table below shows a summary of the medical staffing metrics in critical care at Whittington Hospital compared to the trust's targets, where applicable:

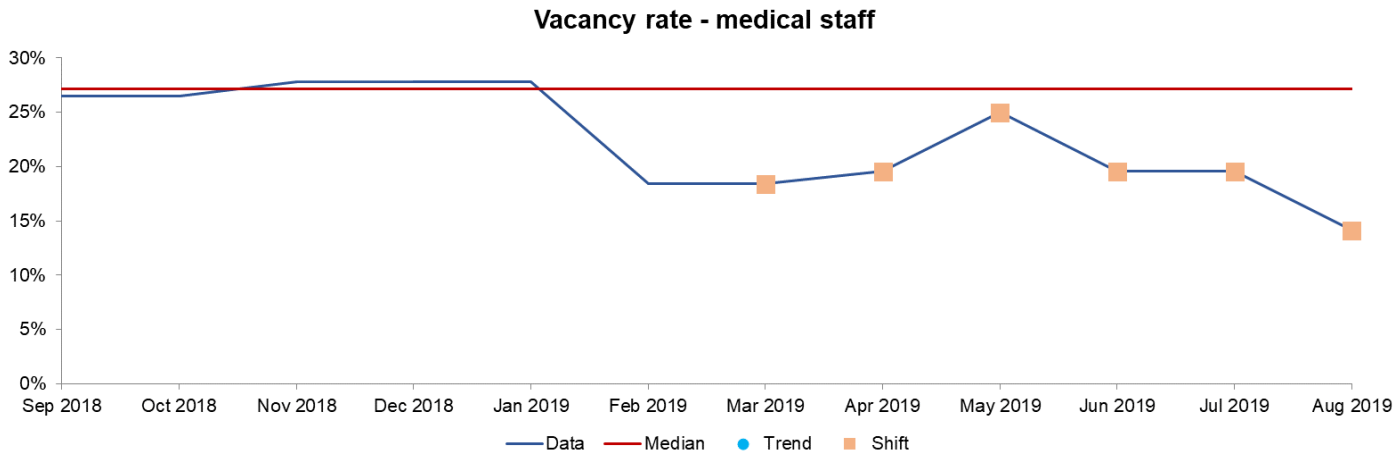
	Critical care annual staffing metrics						
	September 2018 to August 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual locum hours (% of available hours)**	**Annual unfilled hours (% of available hours)**
Target		10%	12%	3.5%			
All staff	70.6	6%	15%	18.1%			
Medical staff	18.2	23%	0%	0.0%	2,696 (8%)	606 (2%)	185 (1%)

(Source: Routine Provider Information Request (RPIR) – Vacancy, Turnover, Sickness and Medical locum tabs)

Medical staffing rates within critical care were analysed for the past 12 months and no indications of improvement, deterioration or change were identified in monthly rates for bank use. There is not enough variation in the turnover rates or sickness rates over the last 12 months for medical staff to comment on the performance of this metric over time.

Vacancy rates

The service had low/and/or reducing* vacancy rates for medical staff.



Monthly vacancy rates over the last 12 months for medical staff show a shift from March 2019 to August 2019.

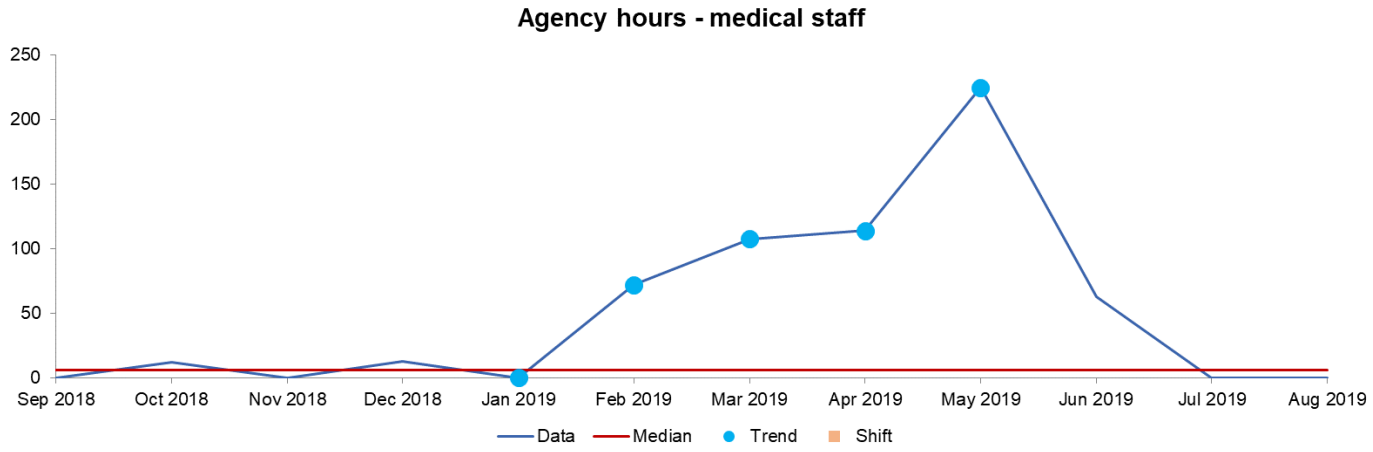
(Source: Routine Provider Information Request (RPIR) – Vacancy tab)

Turnover and sickness rates

The service had low and/or reducing turnover and sickness rates for medical staff.

Bank and locum staff usage

The service had low/and/or reducing* rates of bank and locum staff.



Monthly agency hours over the last 12 months for medical staff shows an upward trend from January 2019 to May 2019.

(Source: Routine Provider Information Request (RPIR) – Medical locum agency tab)

Oversight for medical staffing on CCU was provided by the clinical lead. Staff we spoke with stated medical leadership was visible on the wards and assessible when needed, and that there were regular meeting opportunities for medical staff of all grades.

Consultants were available on CCU every day be 8:30am and 7pm. Out of these hours a consultant was available remotely for telephone advice and, if needed, to attend the ward. Junior doctors told us they could easily contact the on-call doctors if needed for support. The provision of consultant cover on the unit was compliant with recommendations from the FICM Core Standards for Intensive Care Units.

Consultants were supported on CCU by a range of specialist trainees, foundation year 2 doctors, and core trainees. During the daytime shift (8am to 6pm), a registrar supported the critical care consultant on each ward. Overnight, a registrar was responsible for CCU and supported by a senior house officer, with support available from on-call consultants if needed.

Staff stated there was a positive relationship between the consultants and junior medical staff. Junior staff felt well support, and consultant were positive about the quality of trainees they worked with. Staff also stated that if there were gaps in the junior doctors' rota, consultants could provide cover.

Doctors completed a formal ward round twice each day and decided on a management plan for each patient; this was in line with recommendations by the FICM Core Standards for Intensive Care Units. We observed ward rounds on inspection and found them to be well attended by medical staff, but rounds did not include much input from other clinical disciplines. Ward rounds also included opportunities for junior doctors to present patients.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date and easily available to all staff providing care.

Patient records for critical care patients were completed in paper form, and the service used a patient risk assessment tool which included risks assessments for deteriorating patients.

At the time of the last inspection we found inconsistencies in record completion. Patient records on this occasion were legible and generally well completed. All records had detailed notes of the patient care from different disciplines, treatment plans, completed risk assessments, and results of any diagnostic tests the patient had received.

Patients' observation charts were kept by the patient's bedside or just outside their rooms, and staff would input data at regular intervals. Once completed for the day they were added to the patient's records.

Information governance was part of mandatory training for all staff. Staff stated the hospital had a management of health records policy detailing the process for managing and completing patient records. We observed staff ensuring patient records were put away when not being used, which complied with the information governance practices set out in the trust policy.

Where patients were discharged or transferred out of the unit, there was a specific handover sheet / discharge summary from the medical team and a separate one for nursing staff. We saw examples of discharge summaries for a patient during the inspection and found it was fully completed, contained all necessary information and was easy to understand.

CCU had access to the Coordinate My Care, an electronic system which provided patients with access to information about their records and care preferences. This included information on care plans, and what the patient may wish to happen if they became less well. The record could also be shared with your GPs, community nurses, and others involved in the patients care.

Staff stated that there was regular audits carried out to ensure the quality of records. The most recent records audit was completed in September 2019. The audit looked at a random sample of records from critical care, and showed over 95% of entries were completed in black ink, dated, signed and legible, kept abbreviations to a minimum, and all student entries were countersigned. The audit also identified some areas for improvement such as that corrections needed to be dated, signed or the original writing visible beneath the crossing out.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

There was a critical care specialist pharmacist allocated to the unit from 9am to 5.30pm Monday to Friday. Outside of these hours, an on-site clinical pharmacist was available at weekends from 9am to 5.30pm and an on-call pharmacist was available to provide advice to staff 24-hours a day.

The critical care specialist pharmacist aimed to be involved in ward rounds and morning meetings as required. We observed pharmacy staff attending the ward and discussing patient care with ward staff. Critical care staff we spoke with felt they were well supported by the pharmacy team.

We reviewed medication charts in patient records and found them to be consistently completed. The critical care service used a speciality drug chart, which included input from the pharmacy team and critical care staff. Staff documented patient medication risks, such as allergies, as necessary. We found that prescription charts were legible and were reviewed by pharmacists where needed.

Medicines were administered and stored securely in accordance with the medicines management policy of the hospital. The service had access to a provider wide specialist pharmacy advisor who supported compliance with legislation and best practice.

Controlled drugs were stored and managed appropriately. Drugs were kept in lockable units and staff performed twice daily checks of the controlled drugs to ensure they were accounted for.

Medicines requiring cool storage were stored in refrigerators. Fridge temperatures, as well as the temperature in the medication room, were recorded daily. However, we found temperatures in the medication room regularly raised above the recommended range. This issue has been escalated and was being monitored.

Patients were assessed for any potential allergies to clinical equipment or medications on admission. We observed allergy assessments completed in the patient record.

Medication errors were reported and investigated as incidents. Staff we spoke with stated that, depending on the type of incident, medication errors would be investigated with input from both pharmacy and critical care staff. Staff stated that they received feedback on incidents related to

medication.

The pharmacy team had a programme of medicine audits that ran at various cycles throughout the year to ensure compliance with legislation and best practice. This included audits of safe storage of medication, controlled drugs, review of medication charts, and prescribing. We did not identify any concerns in these audits. Pharmacists had also completed recent bespoke audits for critical care, including for availability of resuscitation medication.

Incidents

The service managed patient safety incidents well. Staff recognised incidents and near misses and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Never Events

The service had no never events on CCU. Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need have happened for an incident to be a never event.

From October 2018 to September 2019, the trust reported no never events for critical care.

(Source: Strategic Executive Information System (STEIS))

Managers shared learning about never events with their staff and across the trust. The division for critical care, which included surgery, had four never events in the period between October 2018 to September 2019. Staff we spoke with were aware of these incidents, and we saw divisional governance minutes reflected discussion of these incidents.

Breakdown of serious incidents reported to STEIS

Staff reported serious incidents clearly and in line with trust policy.

Trust level

In accordance with the Serious Incident Framework 2015, the trust reported two serious incidents (SIs) in critical care which met the reporting criteria set by NHS England from October 2018 to September 2019. A breakdown of incidents by incident type is below.

Incident type	Number of incidents	Percentage of total
Sub-optimal care of the deteriorating patient meeting SI criteria	1	50%
Pending review	1	50%
Total	**2**	**100%**

(Source: Strategic Executive Information System (STEIS))

There was an electronic incident reporting system in place across the trust and staff knew how to report an incident. Staff told us they also received feedback from incidents reported that were

investigated, either through team meetings or by direct feedback. Staff met to discuss the feedback and look at improvements to patient care. Staff stated they were generally well informed about incidents and investigations relating to critical care, and major incidents across the trust.

Incidents were monitored by senior staff and depending on the type of incident, investigated to identify areas for improvement. Critical care and the wider division held monthly governance meetings to share information on incidents and to discuss changes to service delivery from reported concerns. These were minuted for staff who could not attend.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong. All staff we spoke with were aware of the duty of candour and knew the circumstances to which they applied it. The incident policy reflected the hospital's requirement to be open and transparent with patients when there had been an incident and outlined the procedure by which patients would be involved or informed in the investigation process. We saw this reflected in investigations of serious incidents we reviewed.

Safety thermometer

The service used monitoring results well to improve safety. Staff collected safety information and shared it with staff, however it was not all clearly visible to patients and visitors.

Safety thermometer data was not displayed on the ward for staff and patients to see. Some safety thermometer indicators were displayed on the quality board in the main corridor (but not all) and some metrics were presented under the nursing quality indictors which was displayed in the staff room.

The lack of displayed safety thermometer data was raised to divisional leadership on the surgery inspection, and the trust stated quality and safety boards were under review to ensure all relevant safety thermometers were included.

Staff used the safety thermometer data to further improve services. The safety thermometer is used to record the prevalence of patient harms and to provide immediate information and analysis for frontline teams to monitor their performance in delivering harm free care. Measurement at the frontline is intended to focus attention on patient harms and their elimination.

Data collection takes place one day each month – a suggested date for data collection is given but wards can change this. Data must be submitted within 10 days of suggested data collection date.

Data from the Patient Safety Thermometer showed that the trust reported no new pressure ulcers, falls with harm and new urinary tract infections in patients with a catheter from August 2018 to August 2019.

(Source: NHS Digital)

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and best practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Care and treatment was delivered to patients in line with National Institute for Health and Care Excellence (NICE) and Royal Colleges guidelines. Staff followed national and local guidelines and standards to ensure effective and safe care. National best practice was reflected in the policies we reviewed.

Staff assessed patients' needs and planned and delivered patient care in line with evidence-based, guidance, standards and best practice. Delivery of care on the critical care unit (CCU) was informed by standards and recommendations in the Guidelines for the Provision of Intensive Care Services (GPICS), developed by the Faculty of Intensive Care Medicine (FICM). There were a few areas not meeting GPICS standards, and these have been identified in the relevant sections of this report.

Staff had access to the trust policies and guidelines via an intranet. Paper copies of local protocols and policies were also available to staff. All protocols and guidelines we reviewed were in date. We also saw evidence where protocols and pathways were amended following newly identified risks or service need.

Care was delivered in line with best practice for treating critical care patients. Patients were monitored using the National Early Warning Score (NEWS), and the ward followed the Sepsis Trust guidance on the initial management of septic patients and used the 'Sepsis Six' approach as recommended to provide consistent care. Sepsis Six is the name given to a bundle of medical therapies designed to reduce mortality in patients with sepsis.

The service also contributed and uploaded data regularly to the Intensive Care National Audit Research Centre (ICNARC), which provides information/feedback about the quality of care to those who work in critical care to allow service benchmarking against similar critical care units nationally.

The service actively engaged with the local critical care network to help support and improve delivery of high-quality care in the area. As members of the North East North Central London Adult Critical Care Network (NENCL), senior staff participated in regular meetings and shared feedback from these with staff. The service also received quality improvement peer review visits from other members of the network

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary.

Staff made sure patients had support with nutrition and hydration to meet their needs. The unit

had access to a dietitian who could assess new patient's dietary needs as necessary. Specialist dietetic support was available from 8.30am to 5pm Monday to Friday on the critical care unit. This complied with the FICM standard stating "critical care units must have access to dietitian five days a week during working hours". Staff told us that the dietician was available to provide advice and support if needed.

Staff fully and accurately completed patients' fluid and nutrition charts where needed.
Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. We reviewed patient records on inspection and found that the nutritional needs of patients were monitored using a nutrition assessment tool. Records reflected the use of fluid balance charts for each patient, as well as evidence of intravenous feeding when patients were not eating or drinking.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. We observed patients being provided with meals, and visitors to the ward being offered refreshments by staff. Patients we spoke with were positive about the food and stated there was options to meet any dietary or religious requirements. Lunch and evening meal times were protected

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain, and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave pain relief to ease pain.

We observed staff on the ward discussing pain management with patients. Patients stated that they felt their pain relief was discussed as part of their care, and we saw this reflected in the patient records. We saw that staff could also communicate with non-verbal patients using visual cues if needed.

The trust had a dedicated acute pain service to provide advice and support to staff regarding pain relief for patients. The pain team included a chronic pain consultant and a pain nurse. Staff stated they were aware of how to access the team. The pain management service was available seven days a week, with anaesthetic consultant cover out of hours.

The critical care ward also had a dedicated link nurse for pain management which staff were aware of. Staff assessed patients pain using a recognised tool and gave pain relief in line with individual needs and best practice.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

The service participated in relevant national clinical audits. The service contributed and uploaded data regularly to the Intensive Care National Audit Research Centre (ICNARC), which provides information/feedback about the quality of care to those who work in critical care to allow service benchmarking against similar critical care units nationally.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The service had a lower than expected risk of readmission for elective care than the England average. The service also had a lower than expected risk of readmission for non-elective care than the England average.

ICNARC Participation

The trust has one unit which contributed to the Intensive Care National Audit Research Centre (ICNARC), which meant that the outcomes of care delivered and patient mortality could be benchmarked against similar units nationwide. We used data from the 2017/18 Annual Report. *(Source: Intensive Care National Audit Research Centre (ICNARC))*

ICNARC results

The table below summarises performance at the critical care unit at Whittington Hospital in the 2017/18 ICNARC Audit.

Metrics ***(Audit measures)***	**Trust performance**	**Comparison to other Trusts**	**Met national standard?**
Crude non-clinical transfers *(transfers made for non-clinical reasons often relate to patient flow and capacity issues which may add to patient risk, prolong intensive care unit stay and cause distress to patients and carers)*	0.0%	Within expected range	Met
Crude, non-delayed, out-of-hours discharge to the ward proportion *(Discharge out-of-hours is associated with increased risk of mortality)*	1.4%	Within expected range	Did not meet
Crude delayed discharge (% bed-days occupied by patients with discharge delayed more than 8 hours) *(Discharge from critical care should be within four hours of decision to discharge and occur as early as possible in the day*)	3.6%	Not in the worst 5% of units	Did not meet
Risk-adjusted hospital mortality ratio (all patients) *(Risk-adjusted measures take into account the differences in the case-mix of patients treated*)	1.1	Within expected range	No current standard
Risk-adjusted hospital mortality ratio for patients with predicted risk of death less than 20% ('lower risk' patients)	1.4	Within expected range	No current standard

(Risk-adjusted measures take into account the differences in the case-mix of patients treated)			

(Source: Intensive Care National Audit Research Centre (ICNARC))

The service submitted data to the Intensive Care National Audit & Research Centre (ICNARC) for all patients treated within the intensive care setting. This meant care delivered and patient outcomes were benchmarked against similar units nationally.

There was staff with dedicated time to collect ICNARC data on a weekly basis. We observed staff being provided with this time. ICNARC data had previously been audited to monitor the quality and accuracy of data submission, however it was not clear on inspection if this was now taking place.

Following inspection, the hospital provided the most recent ICNARC report. Results showed that patient outcomes and mortality were within the expected ranges when compared to similar services.

Managers and staff carried out a comprehensive programme of repeated audits to check improvement over time. The critical care ward carried out an annual programme of audits to evaluate the quality of care being received by patients and overall performance. The results were reviewed during regular quality and safety meetings quality (both at ward level and divisional), and changes to service delivery were planned as necessary. The Critical Care Outreach Team (CCOT) team also had a programme of audits, which in the last year had included audits on sepsis and deteriorating patients in theory caseload.

Following inspection the trust provided evidence of the critical care annual audit programme. This included regular and one off audits to review the quality of service being delivered. The audit programme included leads from medical, nursing and allied health professionals (AHPs), and there was a nominated audit lead to monitor progress and deadlines.

Critical care were part of the peer review process for the North East North Central London Adult Critical Care Network (NENCL). The review was carried out in October 2018, and led by critical care experts from other network services. The services compared to each other locally through a North London critical care dashboard. The service also nominated staff from critical care to take part in divisional quality walks as peer reviews for other services.

Following inspection the trust provided evidence of the most recent peer review by the NENCL. The summary stated that the critical care ward was “a very good Critical Care unit consistently delivering good care and exceptionally good results. We found a great environment with very professional staff working with good resources and facilities.” The report included recommendations, among others, to “establish a clearly defined system for departmental governance”, “replace the current ventilators” and the “development of electronic patient records”.

The critical care ware contributed data to the divisional nursing clinical quality indicators on a monthly basis. The monthly results of this were published as a scorecard comparing the current month to historical performance. The score card included quality indicators for the safety

thermometer, infection prevention and control, bed management statistics and staffing. We observed that the quality indicators were also published each month and displayed in the staff room.

Managers and staff used audit results to improve patient outcomes. Managers investigated audit outliers, implemented local changes to improve care and monitored the improvement over time. We reviewed minutes from governance meetings for critical care and found they reflected discussion of performance in local and divisional audits.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development, however the ward was not meeting the trust target for appraisals across all disciplines.

Appraisal rates

From October 2018 to September 2019 82.5% of required staff within critical care received an appraisal compared to the trust target of 90%.

Staff group	October 2018 to September 2019				
	Staff who received an appraisal	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Nursing and midwifery registered	42	49	85.7%	90%	No
Medical and dental*	3	4	75.0%	90%	No
Additional clinical services	1	2	50.0%	90%	No
Administrative and clerical	1	2	50.0%	90%	No
Total	**47**	**57**	**82.5%**	**90%**	**No**

* Note that data for medical and dental staff was provided separately by the trust and shows appraisal compliance as at October 2019.

(Source: Routine Provider Information Request (RPIR) – Appraisal tab)

Qualified nursing staff

As at 25 September 2019 the trust reported that 90 nursing staff had a post registration award in critical care nursing.

The unit breakdown is shown below:

Unit	Total number of nursing staff in unit (qualified)	Total number of nursing staff with post registration award
Critical Care Unit (Adults)	47	37
High Dependency Unit (Paediatrics)	22	12

There were also 110 staff with training in specialised equipment.

The unit breakdown is shown below:

Unit	Total number of staff (qualified and unqualified)	Total staff with up to date training in specialised unit equipment
Critical Care Unit (Adults)	47	47
High Dependency Unit (Paediatrics)	22	22

(Source: Acute Routine Provider Information Request (RPIR) – CC-staffing tab)

The critical care ward was not meeting the trust target for appraisals across all disciplines. The staff we spoke to stated that they had received an annual appraisal as part of their roles and had found it useful.

Managers made sure all staff attended team meetings or had access to full notes when they could not attend. CCU had a regular calendar of weekly and monthly meetings to monitor performance and staffing, as well as twice daily handovers. However, there were limited opportunities for cross discipline meetings, which is covered in more detail in the multidisciplinary working section.

Staff we spoke with were positive about the support and availability of the practice development nurses (PDN). PDN roles were split between clinical and development, and they provided advice and support to staff on training, personal development, and revalidation. PDNs also delivered bespoke training to critical care staff as requested, or to support improvements to the delivery of care. Staff had a weekly training session in critical care each Tuesday.

The PDNs also supported new staff into their roles as part of local induction. New staff completed a trust induction (including mandatory training), followed by competency assessments, and supernumerary shifts as necessary. They received induction packs and national competency framework to complete in one year. New staff we spoke with were positive about the support they had received.

Agency staff received an induction checklist, orientation around the unit including equipment, covered key areas and the structure of the day. Staff told us agency nurses received effective patient handovers and were generally supported by more experienced staff.

The CCU met the Intensive Care Society standards for registered nurse work force. This included ensuring a dedicated clinical nurse educator for critical care nursing staff, all newly appointed nursing staff receiving a period of supernumerary practice, and a minimum of 50% of nursing staff possessing a post registration award in critical care nursing.

The trust offered a management development programme to support experienced band 6 nurses to develop their management skills, which included taking on shift coordinator responsibilities and spending time working with the outreach team.

The CCOT required staff to have experience of working in critical care or emergency response in order to be part of the team. Staff we spoke on the ward were positive about the experience within the CCOT and felt well supported by them if they needed their input.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients, however we observed that MDT working could improved. They supported each other to provide good care.

The critical care provision included the input of consultants and junior doctors, nursing staff, and a range of allied health professionals (AHPs). In clinical areas we observed the different disciplines worked collaboratively. However, there were limited opportunities for staff to work together across disciplines and meet together as a multidisciplinary team (MDT). This was reflected in conversations with staff, who stated that while there was a good working relationship across disciplines, staff could be “siloed”. Staff stated this had improved under the more recent nursing leadership.

Following the inspection, the trust recognised this had previously been an issue and responded. The trust stated the interim CCU lead had reviewed this and widened attendance to support MDT learning across disciplines for key departmental meetings. The aim of this was to support multidisciplinary learning, including in monthly department governance meetings, monthly morbidity & mortality meetings, and across the external North East North Central London Adult Critical Care Network (NENCL) meetings. These meeting had not been multi-disciplinary previously. The interim CCU lead also agreed plans to introduce bi-annual whole unit days across staff disciplines.

Critical care patients had access to multidisciplinary input to provide rehabilitative care as necessary. The critical care team had dedicated physiotherapists to meet rehabilitation needs in line with The National Institute for Health and Care Excellence (NICE) clinical guidance rehabilitation after critical illness in adults [CG83 83]. On inspection we observed physiotherapists working with patients and discussing their care, and input from physiotherapists reflected in the patient record.

The CCOT completed weekly reviews of medical ward patients with other therapies staff and provided education to staff on medical wards to manage critically unwell patients’ risk (such as sepsis and deteriorating patients).

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultant-led ward rounds took place twice daily, seven days a week, in line with FICM core standards.

There was a critical care specialist pharmacist allocated to the unit from 9am to 5.30pm Monday to Friday. Outside of these hours, an on-site clinical pharmacist was available at weekends from 9am to 5.30pm and an on-call pharmacist was available to provide advice to staff 24-hours a day.

Physiotherapy input was available 24 hours a day, seven days a week to critical care. We spoke with physiotherapy staff on the ward and discussing care alongside critical care colleagues.

There was no designated occupational therapy support allocated for critical care patients. However, assessments and advice could be requested from the hospital's senior occupational therapy team seven days a week.

Speech and language therapy (SALT) was not available at weekends. Staff told us nursing staff could lead on some risk assessments such as swallow screening and physiotherapists could assist with respiratory needs of SALT patients particularly relating to tracheostomies.

Specialist dietetic support was available from 8.30am to 5pm Monday to Friday on the critical care unit. Staff told us that the dietician was available to provide advice and support if needed.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Staff on the unit were able to access support from the hospital's psychiatric liaison service, 24 hours a day. Staff we spoke to were aware of how to access the mental health service. Senior staff stated that the ward was also in the process of agreeing enhanced mental health support with allocated time dedicated to critical care.

NHS seven day standards state that hospital inpatients must have scheduled seven-day access to diagnostic services such as x-ray, ultrasound, computerised tomography (CT), magnetic resonance imaging (MRI), echocardiography, endoscopy, bronchoscopy and pathology. Consultant-directed diagnostic tests and completed reporting should be available seven days a week, with one hour for critical care patients. CCU had access to these services through other departments in the hospital.

The CCOT provided an outreach service from 8am to 8:30pm, seven days a week. Overnight cover for critical care was provided by the ward registrar and the night nurse practitioner. Staff we spoke to on the ward told us that the outreach team were very accessible and easy to contact for support.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on the ward. On inspection we saw leaflets that included advice on health promotion for all patients. This included advice on diet and nutrition, smoking cessation, wound management, and warning signs of acute illness. Advice and guidance was also provided on clinical risks such as falls, pressure ulcers, and venous thromboembolism (VTE).

Hospital staff provided advice to patients on managing their care after discharge. We observed staff from different disciplines advising patients on how to maintain their recovery after they had left the hospital. Staff also encouraged patients to contact the ward if they had any questions.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. Staff clearly recorded consent in the patients' records.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. When patients could not give consent, staff made decisions in their best interest, taking into account the patients wishes, culture and traditions.

Staff made sure patients consented to treatment was based on all the information available. Patient information leaflets and records included information that helped patients provide informed consent.

Mental Capacity Act and Deprivation of Liberty training completion
Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff completed training on the Mental Capacity Act and Deprivation of Liberty Safeguards achieving the trust's target.

The trust set a target of 90% for completion of Mental Capacity Act (MCA) and deprivation of liberty safeguards (DoLS) training.

The trust reported that their safeguarding adults level 1 module covered MCA level 1 training and the safeguarding adults level 2 module covered MCA level 2 and DoLS training.

A breakdown of compliance for MCA/DOLS training courses as at 31 August 2019 at Whittington Hospital for qualified nursing staff in critical care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	54	54	100.0%	90%	Yes
Safeguarding adults level 2	51	54	94.4%	90%	Yes

In critical care the target was met for both of the two MCA/DOLS training modules for which qualified nursing staff were eligible.

A breakdown of compliance for MCA/DOLS training courses as at 31 August 2019 at Whittington Hospital for medical staff in critical care is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	17	17	100.0%	90%	Yes
Safeguarding adults level 2	9	17	52.9%	90%	No

In critical care the target was met for one of the two MCA/DOLS training modules for which medical staff were eligible. Safeguarding adults level 2 training was completed by 52.9% of staff. This equated to eight members of staff not completing the module.

(Source: Routine Provider Information Request (RPIR) – Statutory and Mandatory Training tab)

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. Managers monitored the use of Deprivation of Liberty Safeguards and made sure staff knew how to complete them.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary.

Staff implemented DoL safeguards in line with approved documentation. Staff clearly recorded consent to treatment in the patients' records as necessary. We saw examples of mental capacity assessments also completed in the patient records.

Is the service caring?

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. During the inspection we saw most staff treating patients with dignity, kindness, compassion, courtesy, and respect. Staff explained their roles to patients (including identifying themselves to patients who were not conscious) and put patients at ease during any interactions.

Patients said staff treated them well and with kindness. We spoke with four patients on the critical care ward during the inspection. Patients spoke very positively about the care they received and how they were treated. Patients told us staff were respectful and provided them with space to ask questions about their care. Patients also stated that staff were professional and well informed about their treatment.

The critical care ward displayed thank you cards on some notice boards, and later kept a folder of these cards, that staff received from patients and relatives who had been on the unit. Comments

in these cards included: “a huge thank you for your care”, “thank you for helping me get better” and “I would like to express my thanks and gratitude to all of the staff”.

Staff followed policy to keep patient care and treatment confidential. We saw that patient’s privacy and dignity was maintained whilst they were on the unit. Staff ensured patients were covered up when moving, and received consent to continue before delivering care to the patient. Staff generally closed the curtains around the patient’s bed space on the main ward before carrying out any personal care, however we observed one instance where a patient in an isolation room was receiving personal care, and the blinds for the room were no closed.

The critical care ward provided patients and families with feedback forms for the Friends and Family Test (FFT). The FFT asks people who use services whether they would recommend the services they have used, giving the opportunity to feed back on their experiences of care and treatment. However, staff informed us that because CCU discharged to surgical or medical wards, the responses from their patients was collated into the overall results for surgery and medical wards. The service did not have any other survey to monitor the experience of patients and relatives using their service. This had also been identified as an issue on the previous inspection but had not been addressed.

Following inspection the trust provided response to the lack of a patient survey for critical care wards. The trust stated they were reviewing the current patient feedback mechanism and would formalise the findings into a report with a view to introducing some method of patient feedback. This work was due to be completed in January 2020.

On the critical care ward we saw “you said we did” boards. These boards identified feedback that had been received from service users or family members, and changes that the ward had made based on this information.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. The service lead informed us they were in the process of agreeing dedicated input from a psychologist for patients on CCU as needed.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients personal, cultural and religious needs.

Spiritual and pastoral support was provided by the hospital’s chaplaincy service. There were chaplains of different faith traditions available to reflect the range of beliefs in the local community. Patients and their relatives could access this service via critical care staff or by attending the chapel or multi-faith room within the hospital.

Most staff understood the impact that patients' care, treatment and condition had on their wellbeing. Staff stressed the importance of treating patients as individuals and this was reflected in the interactions we observed. Staff also demonstrated they would be empathetic when having

difficult conversations with patients and families.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Staff provided reassurance and support for patients throughout their care. Staff demonstrated a calm and reassuring attitude to put patients at ease. We observed staff taking time to explain their treatment to patients and asking them if they had any questions about their care.

The unit used patient diaries, and we saw examples of these being used on the ward. Patient diaries provided a daily record of each day's event whilst a patient is in intensive care. Visitors (family members or friends) and staff were encouraged to fill in these diaries with information for the patients, so that they could be aware of things they may have missed. Supporting patients with a better understanding of what has happened to them in critical care may help to set realistic goals for recovery and minimise the risk of adverse long-term problems (National Institute of Clinical Excellence (2009) Rehabilitation after Critical Illness).

Patients who were approaching the end of their life or required palliative care could be supported by the trust palliative care team. The palliative care team could work collaboratively with the critical care staff to manage end of life patients, and the critical care team had end of life care link nurses to communicate with the palliative care team. Staff were positive about the availability of support from the palliative care team, and arrangements for palliative patients. Where staff had to deliver difficult news, there was a quiet room on the ward where this conversation could be had in private.

The trust had developed bereavement leaflets for family members, which included information on accessing interpreters, advice and contact information for practical arrangements, as how to access local support for dealing with a bereavement.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. We spoke with six family members of patients on the critical care ward. Family members were positive about the care the patients received and stated that staff members were professional and welcoming. Family members also stated they were kept well informed of treatment plans.

Staff supported patients and family members to make informed decisions about their care. There was evidence of discussions of patient care with those close to them in the patient records. We also observed the needs of family members being discussed in the ward round handover meeting by staff, however this was not included in the nursing handovers.

CCU had access to overnight accommodation for family members of patients. The family members of patients on CCU also had access to a waiting room next to the ward, where family members could spend time off the ward. This area had information leaflets on bereavement,

complaints, and information in different languages.

There were information leaflets for family members for each critical care ward. These leaflets contained information on visiting times, lead staff, and hospital amenities.

Critical care staff had opportunities for family members to spend time with end of life patients and to commemorate their loved ones, however some staff were unaware of what resources were available for end of life patients. Families of end of life care patients could receive commemorations for family member, such as handprints or written messages from the patient.

CCU had introduced a twice yearly commemoration event, where family members of patients could return to the critical care ward to talk about their loved ones who had passed away. Staff we spoke with were positive about the event and stated that the feedback from family members had been positive.

At time of the last inspection we noted that the reception desk was not always staffed and therefore relatives would have to wait for a nurse to let them into the unit. Outside of normal hours the reception area was still not staffed. As the visiting room for patients was outside the ward, this meant some visitors could be waiting outside the ward waiting for a response from nursing staff.

Is the service responsive?

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

The hospital chaplaincy was available to meet the religious needs of the local population. The service had Christian, Muslim, and Jewish chaplains, and could also provide access to other local religious groups as needed. A duty chaplain was available on site seven days a week, and the service also offered a 24/7 on-call service. Staff that we spoke with were positive about the available support from the chaplaincy.

The trust has a multi-faith prayer room easily accessible and open 24 hours a day for all faiths. There was also a chapel and Shabbos room available on-site. All three-prayer room had a range of religious texts and recourses necessary for observances.

The critical care unit (CCU) had access to a waiting room and family room where they could discuss sensitive topics in a calmer environment. Patients' family members and carers were also provided with on-site accommodation within the nearby 'relatives' room' to allow them to stay at the hospital overnight, if needed. Staff stated that this was a useful resource to have. Each visitor waiting area contained public information leaflets on the services available throughout the hospital to patients and visitors.

There was clear signage inside the main hospital building, which meant it was straightforward for visitors to locate the CCU. The trust website provided useful information about critical care

(including on the outreach service).

Staff were aware of how to access translation if patients or families were unable to communicate in English. Some staff stated they spoke other community languages so could offer some translation, however also stated that they would use interpreters where appropriate.

Staff stated they could contact security to support them if there were any threats of violence on the ward. Staff stated they felt the security team would be responsive to keep both staff and other patients safe.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. However, the service did still have mixed sex breaches due to the open nature of the ward. Staff appropriately escalated any mixed sex breaches to critical care leadership to be aware of. Where sex of the patient was a significant concern, patients could be managed in the isolation rooms off the main ward, and staff mitigated risks related to mixed sex breaches. Senior leadership stated that they would accommodate single sex accommodation on CCU most of the time but managing the clinical risk of patients across the hospital was the priority.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

At the time of the last inspection, we identified that the follow-up clinic did not ensure all patients received an invitation to a follow up-clinic, therefore the service did not meet with the Faculty of Intensive Care Medicine (FICM) standards. On this inspection we found this process much improved, and staff recognised that there had been a lot of work put into improving attendance for patients. All patients who were ventilated on the unit (or had been on the unit for 48hrs or more) were invited to attend a follow up clinic within three months of being discharged. Patients who attended these sessions were able to talk through their experiences and meet the staff who had cared for them.

Meeting people’s individual needs

The service was inclusive and took account of patients’ individual needs and preferences, however environmental support and staff awareness of dementia and delirium could be improved. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Visiting times for family and friends were 8am to 10am and 2:30pm to 9pm, with protected meal and rest times in between. Staff told us visiting times were flexible and visitors could arrange to visit at a time outside the normal hours if discussed with the nurse in charge. The service also asked that only two patients visited at any one time due to limited bedside space.

CCU met the needs of patients' dietary requirements. A choice of food was available at each mealtime to meet the patients’ needs, including for any religious or spiritual requirements. Patients and family members we spoke with were satisfied with the quality and choice of food on offer.

CCU had access to a multi-disciplinary team of staff able to support the individual needs of the

patients. The ward had access to dedicated pharmacy and physiotherapy input, and could refer to the therapies team for speech and language therapy, dietician, psychology and occupational therapy. Staff could also refer to specialist care teams such as the pain team or palliative care teams.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff told us that patients with any communication difficulties would be provided with additional support, and we observed this being discussed on CCU.

The ward had information leaflets available in languages spoken by the patients and local community. Managers made sure staff, patients and their loved ones and carers could get help from interpreters or signers when needed.

Support for mental health patients was provided by referral to the local mental health trust liaison assessment team. The trust had a contract with this service and support/advice was available 24 hours a day. Service leads stated that CCU was in the process of agreeing additional mental health access for critical care patients as needed.

Staff could also access hospital wide speciality leads (such as for learning disabilities and dementia) to receive advice and guidance on best supporting patients with mental health needs, learning disabilities, or dementia. Speciality leads could also provide ward level training, or get involved in care planning for particularly complex cases.

CCU used an assessment pathway form for delirium and dementia. This included space to identify the individual needs, preferences of each patient, and a pathway of care. Staff stated they could also use a carers passport, to inform staff of patients who had a carer and what support needs they may have. The hospital also had dementia champions on-site who had received specific training, although there was not a dementia champion on CCU.

The CCU had not considered a means of identifying patients with dementia on the ward. Staff did not use visual aids in patient bays or on patient boards to identify dementia patients (such as ‘forget me not’ symbol), and patients with dementia were not identified as such at handover. Senior staff stated that they hoped to have funding to improve the availability of aids for patients with dementia, as well as making the environment more dementia friendly, in the new year.

Although there was an assessment pathway for delirium and dementia, screening for dementia was inconsistently completed. On CCU we found patients who started treatment pathways for delirium but an assessment had not been completed or was not in their records. We observed that clinical governance records had mentioned a reminder for staff to complete this pathway.

Appropriate equipment was available to meet the needs of bariatric patients and patients with reduced mobility. The facilities on the unit were accessible for people with mobility difficulties. We saw the shower room had a chair and handrails and the toilet was accessible for larger patients or those using a wheelchair.

Access and flow

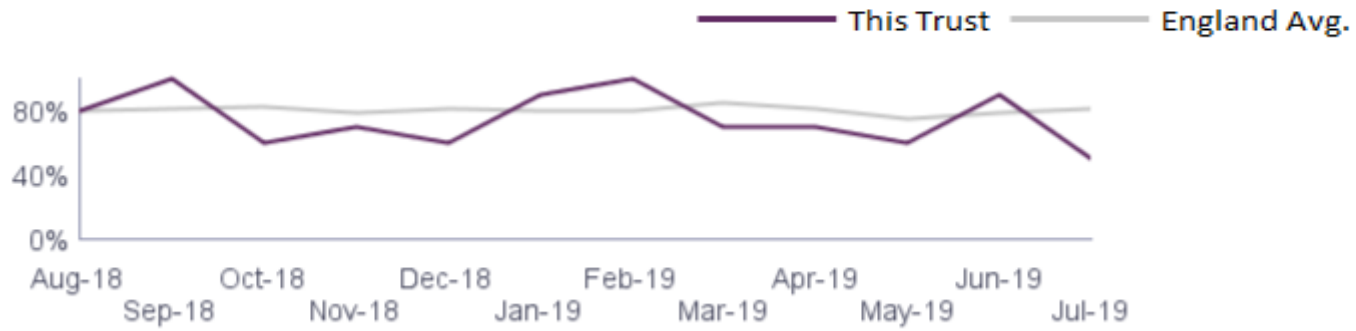
People could access the service when they needed it and received the right care promptly.

The service admitted, treated and discharged patients in line with national standards.

Bed occupancy

From August 2018 to July 2019, bed occupancy ranged from 50% to 100%.

Adult critical care Bed occupancy rates, Whittington Health NHS Trust



Please note that data relating to the number of occupied critical care beds is a monthly snapshot taken at midnight on the last Thursday of each month.

(Source: NHS England)

The Royal College of Anaesthetists recommends that the occupancy rate for critical care wards is kept below 70%. At the time of the last inspection this was between 20% to 60%. Senior staff stated that the occupancy rate was now above the 70% recommended due to the reduced open bed base and higher activity at the hospital. Senior staff stated that while occupancy levels were high, patient safety was the top priority and occupancy was managed as much as possible to facilitate safe care and discharge.

CCU had a mix of patients who had been referred to critical care from the emergency department, post-operative surgery patients, and potentially patients from medical wards or outpatients who had developed critical care needs. The ward was a general intensive care unit with no specialisation, so patients that required specific critical care management would be transferred once they were stabilised and clinically appropriate for transfer.

Managers monitored waiting times for admission and made sure patients could access critical care support when needed and received treatment within agreed timeframes and national targets.

At the time of the last inspection we informed the trust to address the high proportion of delayed discharge, mixed-sex accommodation breaches and the number of patients discharged directly home from the unit.

The Faculty of Intensive Care Medicine (FICM) core standards for intensive care units states that discharge from intensive care to a general ward should occur within four hours of the decision being made. Patients must be moved to a more suitable environment without unnecessary delay and there should not be a non-clinical reason preventing such a move.

During the previous inspection, we raised concerns that a higher than average proportion of patients (79%) who were well enough for transfer to the ward waited more than the recommended four hours. Patients were experiencing a delayed discharge due to bed shortages on the general wards. On this inspection we identified that CCU had significantly improved the number of monthly

delayed discharges by improving communication and monitoring, as well as the discharge process. Between May and October 2019, between 7.3% and 43% of patients (average 35% of patients) waited four hours or more to be discharged from the unit to a ward due to a lack of ward beds.

The ward had also taken action to address the number of mixed sex breaches on the ward. Between May and October 2019, the number of monthly mixed sex breaches varied between zero and eight (with a total of 23). Senior leadership stated that they would accommodate single sex accommodation on CCU most of the time but managing the clinical risk of patients across the hospital would be the priority.

Critical care collected data on delayed admissions, patients length of stay, and the number of people discharged directly to home. As of September 2019, there was a drop-in patient length of stay from 6 days to 4 days since the last inspection, and a 50% drop in the number of delayed admissions to the ward (down from 120 patients to 60 patients). The service also reported a reduction in the number of patients discharged to home, from 84 at the time of the last inspection to 29 within the most recent reporting period.

Staff stated that the service did not have many patients that had unplanned transfers of care into or out of the service (outside of the acute intake or post-operative care). Between May and October 2019, data provided by the trust showed that there were no unplanned transfers of care out of the service, with three unplanned transfers of care in. Staff stated that when this was the case, the patient would be provided with a care plan as quickly as possible and monitored as an acutely unwell patient.

The hospital's bed management policy had included an escalation process to manage delayed discharges, which included specific plans for critical care. The main principles were that all potential patients ready to 'step down' from the critical care unit to the ward would be highlighted by the nurse in charge at the hospital's morning bed management meeting. All patients who were ready to go to the ward were to be transferred to the ward within four hours of the decision being made. The plan then had escalation procedures for patients delayed between four hours, six hours, and eight hours. Delayed discharges were reported on as part of Nursing Quality Indicators for the division.

Managers and staff worked to make sure that they started discharge planning as early as possible. We reviewed patient records on the ward and found that discussions on discharge were proactive and included input from different disciplines. Staff stated that there could frequently be difficulties in stepping down patients to other wards due to a lack of available beds

CCOT nurses provided a follow up clinic for any patient who was discharged from critical care. Follow-up clinics took place three months after discharge for any patient who was intubated, or who had been on a critical care for over 48 hours. Letters were sent out with an offer of an appointment and followed with a phone call.

A dedicated critical care outreach team (CCOT) supported the unit. The CCOT were responsible for supporting staff with all aspects of the critically ill patient-pathway including early identification and assessment of patients requiring admission to the unit and follow-up post discharge. The CCOT also provided educational support to enhance the skills and knowledge of ward staff in

caring for at-risk and deteriorating patients in the general ward areas. Staff we spoke with were positive about the input available from the CCOT. CCOT reviewed any patient discharged from CCU within 24 hours. Each patient is then monitored and followed up with as needed until they leave the wards.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff.

Summary of complaints
From August 2018 to July 2019 the trust received one complaint in relation to critical care at the trust (less than 1% of total complaints received by the trust). The trust took 16 days to investigate and close this complaint. This was in line with their complaints policy, which states non-complex complaints should be closed within 25 days. The complaint was related to lost property.

(Source: Routine Provider Information Request (RPIR) – Complaints tab)

Staff understood the policy on complaints and knew how to handle them. Staff stated they would aim to resolve any patient complaints and concerns immediately. Staff were all aware of the complaints procedure, how to acknowledge complaints, and who had overall responsibility for managing the complaints process.

Managers investigated complaints and identified themes. Any complaints about critical care were reviewed and investigated with input from the leadership of the service. Staff were informed of outcomes from complaints investigations individually, in team meetings, and through quality indicators. We saw critical care quality indicator posters in the staff room, which included information on recent complaints in critical care.

Leaflets on how to make a complaint and contact details for the Patients Advice Liaisons Service (PALS) were visible on the critical care ward and in the waiting room. The complaints process included information about complaints process and how to contact the Parliamentary and Health Service Ombudsman (PHSO) if needed. Patients and family we spoke with were confident they would be supported to make a complaint if needed.

Number of compliments made to the trust
From August 2018 to July 2019 there were two compliments about critical care at the trust (less than 1% of total compliments received by the trust).

(Source: Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Staff were positive about the leadership changes in the last few months, however there were gaps in the skills and abilities to run the service. Leadership were aiming to address morale amongst staff (which was improving) but recent leadership on the ward was

suggested to have negatively impact staff retention.

The critical care provision was part of the surgery and cancer integrated clinical service unit (ICSU) and was led by an associate director of nursing (ADON), a divisional clinical lead, and a divisional manager. Local management of critical care was provided by a clinical lead and general manager and a clinical manager who was covering the vacant matron position. The matron post had been vacant for two months at the time of the inspection.

On inspection staff were clear that there had been a significant tension between ward staff because of leadership issues within the service. Staff we spoke with frequently suggested that there had been bullying behaviour, and that this could have impacted on retention of experienced nursing staff. We were informed that this involved mediation between the leadership and staff following the concerns being consistently reported. Divisional leadership stated that leadership for critical care was a risk on the risk register, as the issue was not yet resolved.

Ward level nursing leadership was provided by an interim clinical manager, who had overall responsibility for the day to day running of clinical areas. At the time of inspection, the interim manager had been in post for two months. Both ward and senior staff we spoke with were very positive about the contribution they had made since they were appointed, and the impact they had on improving morale. However, the interim manager was also responsible for a number of other clinical and training roles at the hospital, and this limited their availability to spend time on the ward. Staff recognised that the ward had a number of experience band 7 nurses who could provide direct support to junior colleagues, however this was not sufficient to ensure consistent oversight of the ward.

Following inspection, the trust stated that the CCU, Resuscitation and Critical Care Outreach Teams have been developed by the interim manager to take on defined responsibilities. This allowed the interim manager to have more managerial management capacity and to be on the CCU on a daily basis. Following discussions, the executive team and the divisional leadership also stated there was agreement that the recruitment process for the nurse leader for critical care and outreach would start in February 2020.

Staff we spoke with stated that the clinical lead and new interim nursing leadership was visible on the ward and were approachable to staff. We also observed critical care staff interacting well with the ward leadership during the inspection. Managers and senior staff on the ward appeared to be approachable.

Staff knew the management arrangements and their specific roles and responsibilities. Nursing and medical leadership provided clinical support to staff, as well as leadership for the delivery of care and bed management.

Junior medical staff said they were well supported by their consultants and medical leadership on the critical care units. Consultants we spoke with were also positive about the support of their colleagues in critical care.

Nursing staff were supported to follow the personal development programmes coordinated by the practice development nurses. Staff we spoke with suggested there were a number of leadership development opportunities including postgraduate courses, rotational posts and mentoring.

Following inspection, the trust provided an update on the changes to leadership on the critical care ward. The results of the investigation into the staffing issues were feedback to the multidisciplinary staff groups and a change programme initiated. This work was led by the interim manager, supported by the lead nurse for surgery and the associate director of nursing (ADON) for the hospital. Staff were being encouraged to raise any concerns with the senior practice development nurses as well as the senior nurse leaders. The staff, particularly the divisional triumvirate, were also supported by the Trust Organisational Development (OD) team.

Vision and strategy

The service did not have a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders, at the time of inspection.

At the time of the last inspection there was no long-term strategy for the critical care unit, and senior staff we spoke with were unable to confirm what the plans for the future of the service were. On this inspection the critical care ward also did not have a long-term plan in place, and senior staff recognised that there was a need to provide consistent ward level leadership.

Following the inspection, the trust provided the surgery and cancer ICSU business plan for 2020/2021, which was at draft stage and included objectives for the critical care unit (CCU). This business plan included initiatives to improved patient experience and embed the new ICSU governance board, implement actions from the CCU staffing investigation, and further develop the critical care network for north London.

Although the business plan identified broad aspirational targets for the coming year, the critical care service did not have a specific vision or strategy plan for the future of CCU. Senior staff recognised that there was not a long-term development plan for critical care, and that that current plans were high level. Divisional leads stated that when developing a strategic vision they would want to do so in consultation with staff.

Culture

Staff felt respected, supported and valued at the time of inspection, however there had been significant staffing issues since the last inspection. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work, and provided opportunities for career development.

Ahead of the inspection and on the ward we were informed that there had previously been tensions within the nursing workforce. Staff we spoke to stated that this had been the case due to tensions between staff across disciplines, because of leadership issues within the service. On inspection staff were positive about the newly appointed interim nursing lead and credited them for having a significant and positive impact. Staff stated that they felt there was now improved morale and that it felt like a different working environment.

On this inspection we found a good working relationship between doctors, nursing, and allied health professionals (AHP). Staff we very positive about their colleagues and we observed a collaborative working culture in place between the various clinical disciplines. However, although staff were working together collaboratively clinically, we found the opportunities for meetings across disciplines were limited.

Staff we spoke with told us that there was a no blame culture relating to safety and they were

encouraged to report incidents. Staff said that they generally felt valued and respected by their colleagues.

Staff demonstrated awareness of the trust values (ICARE, which stands for Innovation, Compassionate, Accountable, Respectful, and Excellent) and information on these values was displayed on CCU. Critical care staff stated that the trust values were embedded well on the ward, and this was reflected in conversations with divisional leadership.

The trust provided occupational health services for staff. The team included occupational health doctors, specialist nurse practitioners, occupational health advisors, physiotherapists, psychologists and health and well-being advisors.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

There was a governance framework in place which oversaw service delivery and quality of care. This included monthly clinical governance meetings across critical care, led by speciality leads and attended by ward staff and allied health professionals. Oversight of governance was provided by the clinical lead for CCU, with divisional oversight provided by clinical director (who chaired the meeting). Senior staff recognised that the clinical governance system was in the process of being embedded, as the changes had just been recently introduced.

We saw records of the last three governance committee minutes and saw they discussed complaints, incidents, key performance indicators (KPIs), training, staffing levels, and any other clinical issues and audits. Actions to address concerns or outstanding issues were identified and monitored through the team meetings (although were not given deadlines for completion). The meetings were minuted for dissemination to other staff who were not able to attend.

CCU also had a weekly meeting, co-ordinated by the interim manager, that was attended by staff. This meeting included discussion of ongoing risks on CCU, actions taken to mitigate risk, incidents, complaints, and any other quality issues. Staff stated they attended this meeting regularly and found it useful.

Critical care governance staff produced a monthly clinical quality report, and this was displayed in the staff room of the CCU. The update included incident trends, risks identified in clinical care, complaints, and upcoming dates for relevant training.

Divisional leads told us that there were monthly morbidity and mortality meetings which included attendance from medical staff (consultants and junior grades), microbiologists, and the critical care outreach. We reviewed minutes from the last three morbidity and mortality meetings and found the meetings were well attended by consultants from CCU.

Management of risk, issues and performance

Leaders and teams had systems to manage performance effectively in the division, however they did not reflect risks in critical care. Identified and escalated risks and issues

were not always reflected on the risk register, with no identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

CCU did not have a local risk register, with risks relating to critical care reflected on the overall divisional risk register. We reviewed the risk register provided by the trust prior to inspection and found it did not reflect the key issues we identified. This had also been an issue on the previous inspection. This included issues related to staffing morale and nursing leadership, staffing vacancies, medical staff training, and non-compliance with Guidelines for the Provision of Intensive Care Services (GPICS) standards.

The main risks identified for the division related mainly to surgery rather than to the critical care provision. This was reflected in discussions with the divisional leadership. Each risk on the risk register also had an action plan to limit any potential risks to patients, and these were reviewed regularly.

Critical care had systems in place to monitor performance, including incidents reporting, clinical governance meetings, patient feedback, audits and staff appraisals. Performance was compared to previous local performance but also compared to similar critical care services in the London area through a peer network. These systems highlighted areas of good practice as well as opportunities for learning.

The trust had escalation plans in place for managing periods of increased patient activity (such as winter pressures). Plans were outlined in the emergency preparedness, resilience and response (EPRR) policy (as well as the bed management and transfer policy). Each policy included specific consideration of CCU in relation to increased activity, management of post-operative admissions, emergency referrals, infection control, and patient transport. The plans did not reflect that the bed base for critical care had reduced from 15 to 10.

Information management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

We spoke with staff responsible for collecting data for internal and external performance monitoring. Staff were involved in collecting information for monthly nursing clinical quality indicators, and for data contributed to the Intensive Care National Audit Research Centre (ICNARC). We were assured that staff were providing accurate data and challenged when they felt information was not sufficient.

All staff demonstrated they could locate and access relevant information and patient records easily, which enabled them to carry out their roles.

Information on policies, news relating to the service, and access to e-learning and trust guidelines, was available through the trust intranet. We observed that staff were able to navigate around the intranet and locate what information they needed.

The CCU practice development nurses (PDNs) produced a monthly newsletter for dissemination to staff on upcoming meetings and relevant dates, feedback from parents, performance issues, top risks for the ward, and recognition of staff contribution. Critical care leadership also shared a 'top four themes of the week' notice, which was displayed around the CCU.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Following the issues of staff morale raised in critical care, the divisional leadership put processes in place to engage with frontline staff on their views. This included offering drop-in sessions with divisional leadership, providing an interim manager, team days run by band 7 nurses, and involving staff in the investigation. At the time of inspection, senior staff recognised that this was an ongoing process, and that there would be further actions to address the staffing concerns in critical care.

There were numerous benefits available to staff at the hospital which included interest-free season ticket loans, support with childcare, accommodation support for first year staff, and a staff counselling and advice service. The trust also recognised the contributions of outstanding staff through the staff recognition scheme, in the form of a monthly and annual awards ceremony. The CCU also recognised staff contribution through the "frog" award.

CCU ran a number of public engagement events for any patients, relatives or carers of patients admitted to critical care. This included a memorial service run twice yearly, ward concerts for patients performed by volunteers, and opportunities to provide to provide feedback to staff in on the ward.

Critical care staff held weekly team meetings and monthly quality and governance meetings. Staff were informed in these meetings about changes to service delivery, areas of shared learning, and any quality or safety issues. These meetings were minuted for those unable to attend. Senior staff recognised that the clinical governance system was in the process of being embedded.

The critical care service participated in the annual staff survey. Overall staff survey results for the trust were shared ahead the inspection. Of 43 combined acute and community trusts, Whittington Health was not placed in the 'best' ranking for any of the 11 themes and were placed in the 'worst' for four of the themes (Equality and Diversity, Health and Wellbeing, Bullying and Harassment, and Morale). Further response by the trust showed that the Surgery and Cancer ICSU was below the trust average across nine of the 11 themes.

The trust provided an update on actions taken to address areas for improvement identified in the staff survey. This included specific goals for the Surgery and Cancer ICSU, based on three themes: engagement, visibility, and leadership. Specific goals included recognising staff contribution through local awards, challenging inappropriate behaviour, and developing middle level clinical management.

The unit formed part of 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.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The CCU had recently received a number of lights for use in patient rooms that simulated levels of light during the day and night cycles. CCU had a consulting leading on the impact that these lights may have on patient satisfaction and recovery. We observed these lights being used in the patient areas. This project was part of a wider research initiative to ‘humanise’ the CCU and offer a less clinical environment for patients.

The CCU was involved in a post-operative spinal surgery quality improvement project. This project aimed to introduce a comprehensive neurological assessment tool to detect early deterioration in post-operative spinal patients, and so improving response from staff. The project had been developed in collaboration between critical care and surgery clinicians.

Critical care had acquired an industry leading patient realistic training mannequin, which was housed in one of the isolation room spaces and could be used for delivering on-ward simulation training. This allowed staff to observe and participate in difficult or risky procedures on responsive mannequins without actual risk. Staff also had access to the trust simulation centre, that was managed by the interim manager for CCU.

Community health services

Community health services for children, young people and families

Facts and data about this service

The trust provides a full range of children and young people's health services across the London boroughs of Haringey and Islington, including health visiting, Family Nurse Partnership (this is a programme providing an intensive, evidence-based preventative programme for vulnerable first-time mothers aged 20 years and under), school nursing and services for Looked After Children. In Islington the health visiting service work together with early years providers from the local authority under the umbrella of 'Bright Start' Islington. Children's community nursing, including nurses in primary care and hospital at home, are delivered in Islington. Continuing care and Life Force are provided across Haringey and Islington along with a wide range of universal and complex needs integrated therapy services and paediatric services. Services are generally provided in health centres as well as schools, community buildings and in the young person's own home.

In addition, the service provides audiology services (new-born hearing screening), community dental services for children with additional support needs in Haringey and Islington plus urgent and emergency dental care for all young people across much of the north and east of London including Enfield, Barnet and Waltham Forest. Services are provided from numerous health centres across five London boroughs.

The service worked closely with a range of partners including other acute and specialist acute hospitals, GP practices, local authorities, schools and special schools and children and adolescent mental health services (CAHMS). As part of its role within an integrated care organisation (ICO), the trust is providing more Consultant-led clinics in community premises.

We carried out an announced visit between 3 – 5 December 2019. We visited the following services: Highbury Grange Health Centre, Hornsey Central Neighbourhood Health Centre, Northern Health Centre, Tynemouth Road Health Centre, New River Green Children's Centre, Kentish Town Health Centre and St Anne's Hospital.

With their consent, we observed young people and their families receiving services and accompanied staff on a new birth visit, observed assessments being carried out, attended a baby weight clinic and visited a school nursing service at a sixth form college in Haringey.

During our inspection we spoke with 98 staff across the service including the clinical director, operations director, service leads, doctors, school nurses, health visitors, occupational therapists, speech and language therapists, physiotherapists, community nursery nurses, community paediatricians and specialist community nurses. We spoke with seven parents, two children and reviewed 20 care and treatment records. We collected feedback from four carers following the inspection.

We reviewed a range of policies and procedures, national and performance data about the trust and other documents relating to the operation of the service.

Information about the sites and teams, which offer community health services for children, young people and families at this trust, is shown below:

Team/ward/satellite name	Services provided	Main base
Audiology and vestibular medicine	Audiology	Whittington Hospital, Adult Audiology service, 4th floor, Magadala Avenue
Archway Children's Centre	Health visiting (Islington Bright Start West)	1 Vorley Road
Belsize Priory Health Centre	Camden children's speech and language therapy (SLT) - early years service	208 Belsize Road
Bingfield Street Health Centre	Health visiting (Islington Bright Start West)	8 Bingfield Street
Blanche Neville School	Therapies team - SLT, occupational therapy (OT), physiotherapy, special school nurses	Muswell Hill
Bounds Green Health Centre	Audiology and vestibular medicine, children in care/looked after children (LAC) Haringey	Gordon Road
Child Development Centre	Children's immunisation service	St Ann’s Hospital, Tottenham
Finsbury Health Centre	Health visiting (Islington Bright Start South)	17 Pine Street
Frank Barnes School	Camden children's SLT - deaf service	105 Camley Street, London
Goodinge Health Centre	Health visiting (Islington Bright Start West)	20 North Road, London
Gospel Oak Health Centre, 5 Lismore Circus	Camden children's SLT - early years service	Gospel Oak Health Centre, 5 Lismore Circus
Hanley Primary Care Centre	Health visiting (Islington Bright Start East)	51 Hanley Road
Haringey Sixth Form College	Therapies team (SLT, OT, physiotherapy, special school nurses)	White Hart Lane
Highbury Grange Health Centre	Health visiting (Islington Bright Start East), school nursing (Islington)	1-5 Highbury Grange
Hornsey Central Neighbourhood Health Centre	Health visiting (West Haringey), school nursing (Haringey), school nursing Safe Talk team (sexual health promotion)	151 Park Road
Hornsey Rise Health Centre	Continuing care (Islington), audiology and vestibular medicine, health visiting (Islington Bright Start East)	Hornsey Rise

Hungerford Children's Centre	Health visiting (Islington Bright Start West)	10 Goodinge Road
Hunter Street Health Centre	Camden children's SLT service - early years service	8 Hunter Street, London
Kentish Town Health Centre	Camden children's SLT service - early years service, Camden child development team, bladder and bowel	2 Bartholomew Road
Laycock Hearing Impairment Unit	Camden children's SLT - deaf service	Laycock Street, London
Linden Children's Centre	Family Nurse Partnership (FNP) - Hackney	86-92 Rectory Road
Michael Palin Centre	Assessment and therapy for children and adults who stammer or stutter	13-15 Pine Street
Netley Campus	Camden children's SLT service - Camden language and communication service	72-76 Stanhope Street, London
New River Green Children's Centre	Health visiting (Islington Bright Start South)	23 Ramsey Walk
Northern Health Centre	Paediatric musculoskeletal, paediatric hospital @ home, community paediatrics Islington: early years development team (SLT, OT, physio, paediatrics), community paediatrics Islington: social communication team (0-5 years) (SLT, OT, clinical psychology, family counselling, paediatrics), special school therapies team (SLT, OT, physiotherapy, special school nurses), community paediatrics Islington: musculoskeletal physiotherapy (children), community paediatrics Islington: mainstream therapies team (SLT, OT, physio), community paediatrics Islington: community paediatricians, bladder and bowel, health visiting (Islington Bright Start East), children's community nursing (Islington), Life Force (Children's palliative care)	580 Holloway Rd, Archway
PULSE	FNP (Islington)	164 Holloway Road
Richard Cloudsley Special School	Therapies team	1 Prebend Street, London

River Place Health Centre, Essex Road	Children's immunisation service, health visiting (Islington Bright Start South)	Essex Road
Riverside Special School	Riverside special school therapies team (SLT, OT, physiotherapy, special school nurses)	White Hart Lane
Samuel Rhodes Special School	Therapies team	Montem community campus, Hornsey Road, London
St Ann's Hospital	Audiology and vestibular medicine, child development team (Haringey)	St Ann's Road, Tottenham
Stuart Crescent Health Centre	Health visiting (North Haringey)	Wood Green
Swiss Cottage School	Camden Children's SLT service - complex needs service	80 Avenue Road, London
The Bridge Special School	Therapies team	251 Hungerford Road, London
The Brook School, Adams Road	Therapies team (SLT, OT, physiotherapy, special school nurses)	Adams Road
The Vale Special School	Therapies team (SLT, OT, physiotherapy, special school nurses)	Trulock Rd
Tynemouth Road Health Centre	Children's SLT service - early years service, FNP (Haringey), health visiting (South Haringey), school nursing (Haringey), parent infant psychology service (PIPS) Haringey	24 Tynemouth Road
Ward G1	Children's SLT service - early years service. Provides services to special schools - Brook, Vale, Riverside, Haringey sixth Form and Blanche Neville	St Ann's Hospital, St Ann's Road, London

(Source: Universal Routine Provider Information Request (RPIR) – P2 Sites tab)

Is the service safe?

By safe, we mean people are protected from abuse* and avoidable harm.

*Abuse can be physical, sexual, mental or psychological, financial, neglect, institutional or discriminatory abuse.

Mandatory training

The trust provided mandatory training in key skills to all staff and made sure everyone completed it. The trust set a target of 90% for completion of mandatory training. At our previous inspection we recommended the service should ensure staff meet the trust's target for staff completing mandatory training. At this inspection we found the service had made improvements. Managers

monitored mandatory training and used a RAG (Red, Amber and Green) rating system to alert staff when training was due to expire. All staff we spoke with told us they had completed their mandatory training or were booked on training sessions. Training compliance rates were robustly monitored by team managers and the heads of service.

Staff advised us they could easily access mandatory training and were clear on which courses they were required to complete for their work role.

A breakdown of compliance for mandatory training courses as at 31 August 2019 at trust level for registered nursing staff in community services for children, young people and families is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Risk management / duty of candour	166	173	96.0%	90%	Yes
Health and safety	163	173	94.2%	90%	Yes
Infection prevention and control	161	173	93.1%	90%	Yes
Equality and diversity	158	173	91.3%	90%	Yes
Information governance	156	173	90.2%	90%	Yes
Conflict resolution	153	173	88.4%	90%	No
Resuscitation	150	171	87.7%	90%	No
Fire safety	150	173	86.7%	90%	No
Moving and handling	140	173	80.9%	90%	No

In community services for children, young people and families the 90% target was met for five of the nine mandatory training modules for which registered nursing staff were eligible.

A breakdown of compliance for mandatory training courses as at 31 August 2019 at trust level for medical staff in community services for children, young people and families is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Health and safety	13	13	100.0%	90%	Yes
Infection prevention and control	13	13	100.0%	90%	Yes
Fire safety	12	13	92.3%	90%	Yes
Information governance	12	13	92.3%	90%	Yes
Conflict resolution	11	13	84.6%	90%	No
Equality and diversity	11	13	84.6%	90%	No
Moving and handling	11	13	84.6%	90%	No
Resuscitation	11	13	84.6%	90%	No

Risk management / duty of candour	11	13	84.6%	90%	No

In community services for children, young people and families the 90% target was met for four of the nine mandatory training modules for which medical staff were eligible. None of these were significantly low and managers were aware of the staff who required to update their training.

(Source: Routine Provider Information Request (RPIR) – Training tab)

Safeguarding

Staff understood how to protect children, young people and adults from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply their learning.

There were clear systems, processes and practices to safeguard children, young people and adults from avoidable harm, abuse and neglect. Staff were aware of indicators of child sexual exploitation (CSE) and female genital mutilation (FGM) and knew how to respond to concerns regarding CSE and FGM.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. Staff demonstrated an effective understanding of their responsibilities in relation to safeguarding children, young people and adults in vulnerable circumstances and were confident to make safeguarding referrals. Staff could explain the process for safeguarding a child or young person.

Staff knew who to contact if they needed advice on safeguarding matters. Each borough had a safeguarding lead, and a number of safeguarding advisors who were available to provide support, training, supervision and updates for staff. Staff knew how to contact them, if they needed advice and support with any safeguarding concerns.

The named doctor for child protection carried out examinations of urgent referrals within 24 hours in cases of suspected abuse. Non-urgent referrals were seen within 14 days.

The trust's electronic patient information system enabled staff to create an alert for children and young people with safeguarding concerns and those who were subject to a child protection plan. The system linked siblings and parents, which raised staff awareness of the needs of other children within the family. Staff had access to this information before conducting a first home visit. Records of safeguarding meetings were kept in the young person's electronic care records.

There were arrangements for safeguarding supervision. This ensured that safeguarding practice was strengthened. Teams attended quarterly safeguarding supervision as a group. All named and designated professionals for child protection, across Islington, Haringey and Camden, received regular group supervision and emotional support. These meetings included reflective discussion and safeguarding updates.

When children moved into another borough staff ensured a thorough handover of safeguarding concerns took place.

When the named doctor for child protection in Islington was also on call for Camden it could be a challenge to see information on the young person's records, as the two boroughs used different records systems

The trust was represented on the local safeguarding children partnership board in each borough with other agencies. The trust took part in serious case reviews (SCR). A serious case review (SCR) takes place following the death of a child, or if a child is seriously injured and abuse or neglect is thought to be involved. They also take place in cases of homicide or criminal activity

involving children. A SCR looks at learning that can help prevent similar incidents from happening in the future. The trust had been named in or involved in seven SCRs within the 12 months prior to our inspection. The local safeguarding children's partnership had oversight of action plans which arose from these. There was evidence that the service implemented changes to practice and learnt as a result of serious case reviews, for example, staff had developed a clear pathway for health visitors to follow up on children who attended the emergency department and were flagged amber or red on the system.

Safeguarding children data was recorded monthly and reported quarterly to the Safeguarding Children Committee, the Whittington Health Quality Committee and the Clinical Quality Review Group (CQRG).

Safeguarding Training completion

The trust set a target of 90% for completion of safeguarding training. At our previous inspection we recommended the service should ensure staff meet the trust's target for staff completing safeguarding training. At this inspection we found the service had made improvements. All staff were trained to level 3 safeguarding. Free training was available from the local authority in each borough. Staff completed training that covered female genital mutilation, gang membership, child exploitation and radicalisation.

A breakdown of compliance for safeguarding training courses as at 31 August 2019 at trust level for registered nursing staff in community services for children, young people and families is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	173	173	100.0%	90%	Yes
Safeguarding children level 1	1	1	100.0%	90%	Yes
Safeguarding children level 2	32	32	100.0%	90%	Yes
Safeguarding children level 3	127	140	90.7%	90%	Yes
Safeguarding adults level 2	149	172	86.6%	90%	No

In community services for children, young people and families the 90% target was met for four of the five safeguarding training modules for which registered nursing staff were eligible.

A breakdown of compliance for safeguarding training courses as at 31 August 2019 at trust level for medical staff in community services for children, young people and families is shown below:

Training module name	August 2019				
	Staff trained	Eligible staff	Completion rate	Trust target	Met (Yes/No)
Safeguarding adults level 1	13	13	100.0%	90%	Yes
Safeguarding adults level 2	13	13	100.0%	90%	Yes

Safeguarding children level 2	2	2	100.0%	90%	Yes
Safeguarding children level 3	10	11	90.9%	90%	Yes

In community services for children, young people and families the 90% target was met for all four of four safeguarding training modules for which medical staff were eligible.

(Source: Universal Routine Provider Information Request (RPIR) – Training tab)

The trust's safeguarding team delivered training on new guidance and changes in legislation, following incidents and serious case reviews. For example, in October 2019 in Haringey the trust held a safeguarding learning event on working with challenging parents to improve access to children; especially those who frequently did not attend (DNA) appointments. This was in response to concerns identified within safeguarding supervision and outcomes from serious case reviews.

Following the London Borough of Islington Joint Targeted Area Inspection (JTAI) of the multiagency response to children experiencing sexual abuse in the family environment in December 2018, the designated safeguarding nurse had developed and implemented a health system JTAI action plan in order to evidence that learning and improvements had taken place to inform frontline practice. The implementation of the Whittington Health JTAI action plan was being monitored by Islington Safeguarding Children Board and within Trust governance arrangements.

Safeguarding referrals

A safeguarding referral is a request from a member of the public or a professional to the local authority or the police to intervene to support or protect a child or vulnerable adult from abuse. Commonly recognised forms of abuse include: physical, emotional, financial, sexual, neglect and institutional.

Each authority has their own guidelines as to how to investigate and progress a safeguarding referral. Generally, if a concern is raised regarding a child or vulnerable adult, the organisation that becomes aware of the concern will work to ensure the safety of the person and an assessment of the concerns will also be conducted to determine whether a referral to Children's Services, Adult Services or the police should take place.

The trust did not provide the required evidence relating to this aspect of care as routinely requested of all hospitals. When we spoke with the head of safeguarding for the trust they reported that as a member of an integrated care organisation (ICO), the trust relied on the data provided regularly by the local authority to keep oversight of referrals made and did not duplicate this information. Quality of referrals were monitored by the local authority safeguarding team and any shortfalls were raised with the trust. Each team had oversight of the referrals they had made.

(Source: Universal Routine Provider Information Request (RPIR) – Safeguarding tab)

Cleanliness, infection control and hygiene

The service controlled infection risk well. Staff kept themselves, equipment and the premises clean. They used control measures to prevent the spread of infection.

At our previous inspection we recommended that Previo that hand hygiene audits and cleaning schedules were in place and were monitored regularly. At this inspection we found the service had made improvements. Hand hygiene audits were in place and cleaning schedules were displayed in community settings.

Clinic areas we visited were visibly clean and had suitable furnishings, which were clean and well-maintained. Staff followed infection control principles including the use of personal protective equipment (PPE). Clinic areas had access to hand washing facilities and PPE, such as disposable gloves and aprons. Community staff carried a supply of infection prevention and control equipment for use when they visited young people at home, such as hand sanitising gel, gloves and cleaning wipes. We saw that staff followed good infection control practices, such as washing their hands before undertaking any clinical duties, for example, health visitors cleaned baby weighing scales and washed their hands between each baby weight check.

Environment and equipment

The community health services for children, young people and families were based at several locations including clinics and primary care centres across the London Boroughs of Hackney, Haringey, Camden and Islington. Services were also provided in schools, children's centres and in people's homes.

At our previous inspection we found that the environment at the Northern Health Centre did not meet the needs of young people and children. At this inspection we found the trust had made improvements. An estates review of the Northern Health Centre had been carried out. The lift had been repaired and was working. Staff had a new kitchen area on the third floor. Many teams were housed at the centre and staff reported that booking rooms could be a challenge.

Doors to restricted areas were secured with key fob/swipe card access to prevent unauthorised access by the public.

In different locations we saw that there were baby changing facilities, rooms for breast feeding, and separate toilets for children only. We also found that that age-appropriate toys were available in most of the waiting areas we visited.

All premises we visited, except St Anne's Hospital, were suitable and had facilities to meet the needs of children, young people and their families. At St Anne's Hospital the environment at the Child Development Centre (CDC) was poor. It was in an old building that was due to be demolished as part of the redevelopment of the hospital site. Rooms had peeling paint on the ceiling. We were informed that the CDC would be moving to new refurbished space as the redevelopment continued.

Staff completed an environmental risk assessment for children and young people being cared for at home. This included any potential risks related to parking, housing, access and pets within the home.

Specialist equipment was provided to care for and treat children and young people in their homes. Staff carried out joint assessments with occupational therapists to determine the equipment needs of children and young people. Staff knew how to obtain equipment. Staff told us they had no difficulties obtaining specialist equipment and could borrow equipment from the hospital to cover any delays, if needed. Families were involved in choosing the equipment if appropriate.

The trust maintained a register of all equipment. Information provided by the trust showed that whilst most equipment was serviced, some equipment did not have dates of servicing. For example, within the Camden Complex and Continuing Care team there were no dates of when

equipment was due to be serviced for three children using the service. This included equipment such as oxygen saturation monitor, nippy vent and nebuliser. Similarly within the Haringey team suction equipment for two children had no dates for service. This meant that children and young people were at risk of unsafe care and treatment because equipment was not being properly maintained.

Children with complex needs were only discharged from hospital when the necessary equipment was in place. Staff ensured an additional ventilator was in place for children ventilated at home, in case of equipment malfunction. Staff ensured parents and carers were competent to use specialist equipment and provided them with training.

At the Child Development Centre in Haringey the service reported problems with orthotics that did not fit properly. They had escalated this problem to managers and were keeping a log of the problems to feedback to the contractor. Health visitors at Tynemouth Road Health Centre reported that there was a shortage of weighing scales when carrying out new born baby visits.

Assessing and responding to patient risk

Staff completed comprehensive risk assessments for each child or young person and updated them when necessary. They kept clear records and asked for support when necessary.
Staff demonstrated a proactive approach in assessing and managing identified risks. Young people's risk was discussed as a standing agenda item at team meetings.

Health visiting staff used a RAG (red, amber green) rating to track children on their caseloads where there were concerns about vulnerability. They used this process to escalate any concerns they had.

Staff would arrange for appointments with children, young people and families to be at a clinic or at their home based on a risk assessment. The youth offending nurse specialist carried out home visits in the presence of parents.

School nursing staff described how they minimised the risk of aggression from young people in secondary schools by ensuring other staff were present during consultations. School nurses followed up on children who attended the accident and emergency department, for example, in a young person's school health record we saw that self-harming risks were being monitored.

The Family Nurse Partnership (FNP) team worked with families experiencing domestic abuse to develop their relationships skills. The FNP team provided early intervention where there was a risk of domestic abuse in families.

We reviewed 20 care and treatment records and found risk assessments were fully completed. For example, in the continuing care children's team risks assessed included communication needs, nutrition and hydration, continence, moving and handling, sleep, pain and skin integrity.

There were arrangements to manage the risks of caring for children and young people with complex physical health needs in the community. Staff in the hospital at home team provided a service 24 hours a day seven days a week. The on-call service was nurse-led but, if necessary, staff could contact a consultant paediatrician 24 hours a day, seven days a week for advice and support.

Staff visited children with complex needs in hospital and worked alongside hospital staff to ensure they fully understood the needs of the young person and family. Staff ensured all care, treatment and equipment needed to safely care for the child or young person in the community was in place before they were discharged home.

Staff completed annual paediatric life support training, as well as basic life support training for adults. At different locations visited we saw there was a defibrillator and oxygen that could be used in the event of an emergency.

Staff put safety measures in place. They taught parents and carers where required how to identify a deterioration in their child and what action to take in the circumstances. One child's care plan contained details for the parents about who to contact if there was a problem with their naso-gastric tube. Treatment plans were in place for a suspected line infection.

Staff carefully risk assessed children requiring 24-hour ventilation to see whether they could be safely cared for at home. Staff explained the risks to parents and carers and fully involved them in the decision to support the child in the home.

The service used the Healthy Child Programme (HCP) to assess and monitor the welfare and development of children, young people and families. This is an early intervention and prevention public health programme requiring staff to screen, immunise, and review the development of children. This also allows staff to identify risk of harm, disorder, ill health, or need for additional support. The service provided additional support through the universal partnership plus service.

Staffing

The service recruited staff to keep children, young people and their families safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

Service leads in each borough reported on the challenges they faced in recruiting health visitors and school nursing staff. There was a recognised national shortage of public health nurses, specifically health visitors. High rates of health visitor and school nurse vacancies were recorded on the service risk register as well as in quarterly reports to commissioners. Haringey school nurses had an average annual vacancy rate of 15%, Islington and Camden health visiting and family partnership 11% and Islington and Camden 20% vacancy rate in the complex and continuing care team. Health visiting teams in Hackney and Haringey faced complex issues with staff sickness and recruitment. The borough leads were working with the human resources department to manage the challenges.

The service trained specialist community public health nursing (SCPHN) students who were funded by Health Education England. In Haringey the service had not been able to recruit any student health visitors for Haringey for 2020.

At the Children's Development Centre in Haringey the special school nursing team had worked with the commissioners to increase the funding to employ another school nurse due to rising needs.

The Continuing Care team contracted complex packages to an agency who provided and trained the care staff who delivered the packages of care to children and young people. The team manager told us it could be difficult to find and sustain the carers to fulfil these roles over time.

The school nursing service in Islington had made changes to their safeguarding work practice in response to staffing challenges. They only attended child protection case conferences if there was an identified clinical need. They said these changes had enabled them to provide more school sessions.

Any staff shortages were responded to appropriately. Cover arrangements were in place for sickness, leave and vacant posts. Teams used bank and agency staff as appropriate.

Managers assessed the size of the caseloads of individual staff regularly and helped staff manage the size of their caseloads. Health visitors and school nursing staff reported that caseloads were manageable. Health visitors in Islington had an average caseload of 372 and in Haringey 519. In the Children's Community Nursing service teams held a team caseload rather than an individual caseload, although there were leads for particular children or a named case manager. Managers reviewed caseloads every week to ensure staff had manageable workloads.
The graph below shows the comparisons of whole time equivalent (WTE) staff in post in community services for children, young people and families from September 2018 to August 2019.

	Core service annual staffing metrics September 2018 – August 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual "unfilled" hours (% of available hours)**
All staff	573.6	8%	13%	16.8%			
Registered nurses	182.9	10%	14%	13.9%	10,007 (3%)	20,478 (7%)	1,575 (1%)
Nursing assistants	124.5	14%	11%	22.7%	6,581 (4%)	3,561 (2%)	504 (<1%)
Medical staff	15.8	45%	0%	5.1%	824 (3%)	0 (0%)	95 (<1%)
Allied Health Professionals	197.7	-4%	13%	15.1%			

The trust set a target of 10% for vacancies. From September 2018 to August 2019 the trust reported an overall vacancy rate of 8% in community health services for children, young people and families. This met the trust's target. Across this core service the overall vacancy rate for nursing staff was 10%; for medical staff was 45% and for allied health professionals was -4% signifying an over-establishment of staff.

(Source: Universal Routine Provider Information Request (RPIR) Staffing data P16 – P21)

During the reporting period from September 2018 to August 2019, community health services for children, young people and families reported that there were no cases where staff had been either suspended or placed under supervision.

(Source: Universal Routine Provider Information Request (RPIR) – Suspensions or Supervised tab)

Quality of records

Staff kept detailed records of each young person's care and treatment. Records were clear, up-to-date and easily available to all staff providing care. Staff used an electronic record system. Staff used laptop computers to enable them to access the electronic system remotely. These were secured using passwords.

All referrals, transfers and discharges were recorded on the system. All staff we spoke with were clear where information about each young person's care and treatment was located. Most staff were easily able to access information when the young person moved between teams. For example, we saw records which detailed that a young person had been seen in the emergency department.

Health visiting staff completed the Personal Child Health Record (PCHR) also known as the 'red book'. This is a paper record which is held by the parent or carer of a child. New birth notification, discharge summary and the pink slip from the red book were shredded following a home visit once details had been recorded on the electronic patient record system.

Looked After Children nurses had access to the local authority electronic client record system. This enabled them to upload reports and create safeguarding alerts to notify the social worker and independent reviewing officer in a timely manner.

Regular records audits were carried out. However, where shortfalls were identified it was not clear what action was being taken to address them. For example, record audits within the Children's Community Nursing Team, the Islington Additional Needs and Disability Service and the Camden speech and language service all identified shortfalls however there were no accompanying actions how these were to be addressed.

Medicines

Staff did not manage medicines in line with best practice guidance. This could place young people receiving medicines from the service at risk of unsafe care and treatment. We reviewed medicines management at the Northern Health Centre. We found out of date medicines including water injections, sodium chloride ampoules, medical grade lubrication, sterile syringes and creams. There were various samples of medicines such as creams which came directly from a pharmaceutical manufacturer (and not the pharmacy department), and some of these were out of date and had been given to young people. In the basement stores we found that temperatures were not monitored for patient-specific medicines. In addition, patient-specific medicines, such as sodium chloride ampoules and nebulisers, were routinely used for young person's other than those for whom it was intended. The medicine fridge did not have a validated temperature probe as it had broken. This was reported in October 2019. However, there was no date of action for when this would be replaced. Temperature monitoring was being completed using the fridge's own temperature reader however this was not validated. The recording of fridge maximum and minimum temperatures was not being completed regularly.

Nursing staff were not able to demonstrate where to find the patient group directions (PGDs) for flu vaccinations or where clinical policies for asthma and formulary details were on the intranet. Staff reported that there were printed copies, but this meant there was a risk that any updates would be missed.

We found that prescription stationary (FP10s) was not kept for each prescriber. They were locked away but could be accessed by a number of people, and therefore there was a risk of theft or misappropriation.

There was no audit trail to show which medicines were used for specific young people in any of the teams. There was no evidence that audits were taking place.

We raised these medicines issues at the time of the inspection and the trust took immediate steps to ensure that medicines were managed safely. This included removing all out of date stock, additional staff training and pharmacy support and development of a local assurance process.

We followed up to check the actions taken by the trust and found they had been responsive and had mitigated the risks identified.

Safety performance

The Children and Young People's (CYP) Integrated Clinical Support Unit (ICSU) safety thermometer measured harm-free care for children and young people. The CYP safety thermometer measured deterioration, extravasation (the leakage of blood, lymph, or other fluid from a blood vessel or tube into the tissue around it), pain, and skin integrity. The local target was for 95% harm- free care. Within the CCYPFS, community children's nurses, Lifeforce, Hospital at Home and complex care contributed to the CYP safety thermometer. For the period October 2018 to September 2019 the service achieved 98% harm free care. The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to children and young people.

Incident reporting, learning and improvement

At our previous inspection we recommended that the trust should ensure that learning from incidents took place. At this inspection we found the service had made improvements. Teams met together regularly and discussed learning from incidents in the team and from across the service. Complaints and serious incidents were standing agenda items in team meetings. The trust produced a 'spotlight on safety' newsletter, which was shared with staff.

The service managed young people's safety incidents well. Staff recognised incidents and reported them appropriately. When things went wrong, staff apologised and gave young people and / or their families or carers honest information and suitable support. For example, at Camden speech and language therapy service an apology had been offered to a parent in relation to records access.

In the period September 2018 to August 2019, staff within community health services for children, young people and families reported no serious incidents.
Managers were aware of serious case reviews that had taken place across the integrated care support unit and lessons identified from them.

Never events are serious patient safety incidents that should not happen if healthcare providers follow national guidance on how to prevent them. Each never event type has the potential to cause serious patient harm or death but neither need to have happened for an incident to be reported as a never event. In the period October 2018 to September 2019, the trust reported no never events for community services for children, young people and families.

Staff knew what incidents to report and could provide examples of changes to practice which came about through learning from incidents. For example, in response to a Prevention of Future Death Report issued by the coroner the trust had taken action in agreement with the national Family Nurse Partnership (FNP); it had made changes to the service referral criteria and the way the health visiting teams offered enhanced health visiting programmes to families with additional needs and vulnerabilities.

Is the service effective?

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice.

Staff provided a range of care and treatment interventions suitable for the patient age-group. The interventions were those recommended by, and were delivered in line with, the National Institute for Health and Care Excellence (NICE) guidance. Health visitors and school nurses delivered the Department of Health and Social Care's national Healthy Child Programme (HCP). The HCP promotes regular contact with every family to include screening tests, developmental reviews and support.

Health visitors used the Ages and Stages Questionnaire 3 (ASQ3), an evidence-based assessment tool that encourages parents to provide information about the development status of their child across five developmental areas.

In Haringey the health visitors ran the Health, Exercise, Nutrition for the Really Young (HENRY) programme. This is an eight-week programme for parents of infants and toddlers aged 0 to 5 years.

In the Family Nurse Partnership team in Haringey staff used Video Interaction Guidance (VIG): which is a therapeutic tool for parents to aid interaction and to help them develop understanding of baby cues.

A range of clinical pathways were in place for specific conditions. For example, the jaundice pathway provided affected babies with light treatment at home to treat the condition. This was a new innovation developed with a local acute hospital. There were strict criteria in terms of acceptance on to the pathway. Parents had reported positively on their experience of the pathway.

Young people on the respiratory pathway received a telephone triage and 48 hour follow up. In Islington the service was carrying out the asthma-friendly schools project which aimed to improve care at school for children and young people aged between five and 18 with asthma. Staff told us that they followed NICE guidance on identifying and responding to deteriorating patients.

The speech and language therapy team at the CDC was piloting an approach called Verve (video, endorse, respect, vitalise, eye contact). This evidence-based approach involved four sessions using video to analyse what worked well between the practitioner and child.

School nurses delivered the national child measurement program (NCMP) to measure the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) and assess obesity levels in children within primary schools. This initiative provided an opportunity for staff to engage with children and families about healthy lifestyle choices.

The children, young people and families service offered a Family Nurse Partnership (FNP) programme providing an intensive, evidence-based preventative programme for vulnerable first-time mothers aged 20 years and under, from pregnancy until the child was two years of age. Family nurses delivered a licensed programme with a well-defined and structured service model. The performance of this programme was monitored to ensure compliance with the national FNP guidelines.

The Looked After Children (LAC) teams supported looked after children, to improve their health and life chances by providing a holistic and educational approach to health assessments.

Staff had access to policies, guidelines and pathways through the trust's intranet. Staff were informed of updated guidance through a variety of means such as team meetings, newsletters and email.

Nutrition and hydration

Most children, young people and families using the service attended community clinics for short periods of time, or were seen in their own homes, therefore, they were not routinely provided with food or drinks.

Staff assessed, monitored and managed each young person's hydration and nutritional needs, where needed. This was confirmed by the young persons' records we reviewed. In the children's community nursing team special feeding and hydration techniques were used when needed, such as enteral feeding tubes (this involves the use of a feeding tube placed into the gastrointestinal tract).

Staff could obtain specialist support from dietitians, speech and language therapists and infant feeding specialists, when needed. Dietitians were available to provide advice to young people, parents and carers about conditions, such as food allergy, tube feeding and diabetes. Staff in the community teams were working with the dietetics team to develop a pathway for children with a cow's milk allergy.

The trust was awarded full accreditation under the UNICEF Baby Friendly Initiative in the London Borough of Islington in May 2015. This means that all Islington midwives, health visitors and other health and children's centre professionals have training to enable them to support parents will have baby friendly training in supporting breastfeeding effectively. Within the London Borough of Haringey staff were working towards achieving full accreditation. New mothers could also access breastfeeding networks across the boroughs for one to one or group support.

A variety of initiatives were in place to support breastfeeding including peer support at breastfeeding drop-in sessions, parent groups, antenatal and baby clinics. Infant feeding co-ordinators within the boroughs provided training complying with UNICEF Baby Friendly guidelines.

The service reported to Public Health England on the number of children fully or partially breastfeeding at six to eight weeks. For the period July 2019 to September 2019 Haringey services completed 100% of breastfeeding assessments and 88% of infants were recorded as breastfeeding. The London Borough of Islington completed 84% of breastfeeding assessments and 34% of children were recorded as breastfeeding. The England average for babies who are breastfed is 44%, so Haringey performed much better and Islington was worse.

The health visiting service and school nursing service worked with children, young people and their carers in the community to maintain a healthy weight by providing advice and information on healthy eating. Child health clinics monitored children's weight. Staff were able to make referrals to children's centres which were commissioned to provide healthy eating support by the local authority. Health visitors carried out baby weighing clinics and offered advice on feeding and introducing solids. School nurses worked collaboratively with parents on promoting healthy lifestyle through coffee mornings, parents' evenings and children's assemblies.

The national child measurement program (NCMP) was delivered by school nurses. The NCMP measures the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children within primary schools.

Pain relief

Staff in community paediatric and nursing teams assessed, monitored and managed young people's pain, where needed. Staff provided children and young people pain relief when required.

Patient outcomes

The service had arrangements in place to monitor people's care and treatment outcomes. Health visitors were delivering all aspects of the Healthy Child Programme (HCP). Ante-natal, new birth visits, six to eight week reviews, one year and two year developmental reviews were delivered universally. At our previous inspection we recommended that the trust ensure that national targets for the HCP were met. At this inspection we found improvements in this area.

The percentage of children who had a face to face new birth visit within 14 days by a health visitor in the period from July 2019 to September 2019 was 92% in Haringey and 94% in Islington and This was below the national target of 95%. Reasons for not meeting the target were clearly recorded on individual records. For example, we saw that a new birth visit had not taken place within 14 days because the baby was in the neonatal intensive care unit (NICU). Teams prioritised visiting high risk mothers.

The percentage of children who had a one year developmental review by 15 months by a health visitor in the period from July 2019 to September 2019 was 84% in Haringey and 82% in Islington. This was above the national target of 80% and a significant improvement from our previous inspection. In Haringey the service had introduced a single point of access team who followed up on all reviews due. They sent letters to parents and followed up with reminder text messages. Where parents were not able to attend specific locations, they were offered an alternative venue.

The service target for the number of children who had received a two year developmental review by 30 months was 80%. In the period from July 2019 to September 2019 the figures were 78% in Haringey and 82% in Islington. We found that the teams in Haringey had made significant improvements from our previous inspection in working towards meeting the target.

School nurses measured the height and weight of children in reception class (aged 4 to 5 years) and year 6 (aged 10 to 11 years) to assess overweight and obesity levels in children within primary schools as part of the National Child Measurement Programme (NCMP). In Haringey 91% of children were measured in reception class and 92% were measured in year 6. In Islington 95% of children were measured in reception class and 95% were measured in year 6. This was lower than the national average of 96% for reception class children and, in Haringey, it was lower than the national average of 94% for children in year 6.

Consultants participated in national audits such as the Epilepsy12 audit. The epilepsy12 audit aims to measure and improve the quality of care for children and young people with seizures and epilepsy.

The occupational therapy team at the Child Development Centre in Haringey had changed their model to focus on outcome-specific interventions. Occupational therapists completed standardised assessments and offered six-session cognitive orientation occupational performance. They used the patient-specific functional scale to assess the impact of their interventions.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff work performance and held supervision meetings with them to provide support and development.

Managers gave all new staff a full induction tailored to their role before they started work. All new staff completed a trust induction and local induction programme, which included mandatory and role-specific training. Staff confirmed they were provided with a local induction when they moved teams.

Staff reported that learning needs were identified through one to one supervision, appraisals, revalidation and team meetings. All staff we spoke with confirmed there were opportunities, support and time to undertake training and professional development to cover the scope of their work. For example, staff in the Hospital at Home Team were encouraged to complete university level modules, including enhanced physical assessment and advanced nursing practice. One nurse was completing an MSc in Dermatology. In the Haringey Early Years Development Team occupational therapists had undertaken training in functional hand use in hemiplegia and sensory coaching skills workshop. Within the Family Nurse Partnership team in Haringey personalisation training had been arranged at a specialist trust and was due to commence in February 2020. Staff had access to coaching training and leadership courses.

Care staff in the Children's Community Nursing Team, were trained for the particular packages of care they delivered. They shadowed hospital nurses and were signed off as competent when they were ready. Care staff became involved in the care of the child or young person before they were discharged from hospital. This allowed them time to get to know families as well as the young person.

The trust provided the following information about their clinical supervision process:

The trust has a clinical supervision policy. The scope includes nurses and allied health professionals as well as doctors. The policy does not require that records are held centrally and does not identify a target rate, so it is not possible to provide a breakdown at the current time.

Managers provided staff with clinical and managerial supervision (meetings to discuss case management, to reflect on and learn from practice, and for personal support and professional development) and appraisal of their work performance. All staff we spoke with confirmed they received regular supervision which they found useful in supporting their knowledge, development and wellbeing. Individual teams monitored the frequency of supervision, however at the Haringey Early Years Development Team there were no arrangements in place to do so.

Managers dealt with poor staff performance promptly and effectively. Staff who were performing poorly received prompt support. Managers assisted staff members to improve in their role. Managers used supervision sessions and action plans to address concerns about staff performance. They were able to access guidance and support from the human resources department.

Staff undertook core competency assessments relevant to their role to ensure they had the appropriate clinical skills and knowledge to manage young people safely and effectively. However, information provided by the trust showed that two staff out of eight staff in the Children's Continuing Care Nursing Team did not have some of their competencies checked for over two years. For another member of staff it was not clear whether key competencies such as medicines management had been assessed. This meant that there was a risk that staff within this team may not have the skills and knowledge to carry out their role.

The clinical psychologist from the children's palliative care team facilitated a monthly support group for staff in the continuing care team.

Staff told us they received an annual appraisal. At our previous inspection we recommended that managers meet the trust target rate for appraisals. At this inspection we found the trust had made improvements and were monitoring appraisal rates robustly. In Islington 97% of staff within the Islington Additional Needs and Disability Service had been appraised and 94% of staff in teams providing universal services. In Camden 100% of staff had been appraised. In Haringey 83% of all staff had been appraised compared to the trust target of 90%. Team managers had good knowledge of the staff who had not been appraised. They told us that gaps related to poor performance, staff sickness and issues with the electronic staff record. Both borough leads reported that there were issues with the recording of appraisals and completion rates on the national electronic staff record (ESR) system and they had raised this at national level through their HR department. All medical staff received an annual appraisal.

Staff held regular team meetings. The frequency of meetings varied between the teams. Meeting minutes were available and shared with staff who were not able to attend.

Multidisciplinary working and coordinated care pathways

All those responsible for delivering care worked together as a team to benefit the young people in receipt of their services. They supported each other to provide good care and communicated effectively with other agencies. Teams across the boroughs included, or had access to, the full range of specialists required to meet the needs of people using the service. These included doctors, nurses, speech and language therapists, occupational therapists, physiotherapists, nursery nurses, dieticians and psychologists. Staff told us they were proud of good multidisciplinary team working, and we saw this in practice. We heard how a doctor had supported the Islington child and adolescent mental health service (CAMHS) at short notice in order to ensure a young person did not go without an assessment when staff there were off sick.

Staff routinely worked across health care disciplines and with other agencies to provide care and support to children young people and families. We saw many positive examples of multidisciplinary and multiagency working which supported effective care planning and delivery. Nurses worked within primary care settings to deliver care to children and young people. It had taken time to build up relationships with GPs, but managers said all involved had developed a better understanding of each other's skills and roles. Specialist health visitors carried out integrated health and development reviews together with parents.

Special school nursing teams carried out joint assessments with staff from different therapies so that parents did not have to attend multiple appointments. The safeguarding school nursing team worked closely with safeguarding social work teams, GPs, school nurses, youth offending teams and CAMHS.

Staff we spoke with during our inspection provided positive feedback about working relationships with colleagues from different specialties and staff groups. All team members were aware of who had overall responsibility for each person's care. This was recorded on the person's electronic record.

Looked After Children's nurses in Haringey carried out a monthly floor walk at the local authority social care offices. This enabled them to have one-to-one engagement with social workers who were allocated to children that were coming up for review. These included social workers from the children with disabilities team and the local authority young adult service. This enabled all professionals involved in the child's care to share information.

Transition arrangements were flexible and tailored to children and young people's individual needs. Staff described transition to adult services as the most difficult. For example, staff in the Children's Community Nursing Team reported that adult teams sometimes used different types of equipment and were unfamiliar with equipment used by the young people. The trust was working to improve the process of transition for young people and a draft transition policy was awaiting sign off. The aim was for the children's teams to work closely with the adult teams in the first year following transfer, with standard operating procedures underpinning this. Where children were preparing for transition, they had a transition care plan in place.

The emotional health and wellbeing service practitioners went into schools to offer programmes to local children and families for low level mental health support. Children and young people requiring further mental health treatment were referred to the local CAMHS. There was evidence of the service working collaboratively with CAMHS services to develop pathways and review service provision

The Parent Infant Psychology service (PIPS) worked closely with perinatal units and attended all referral meetings.

Health promotion

Staff gave young people practical support and advice to lead healthier lives.

Staff promoted a healthy lifestyle in discussions with families and during care and treatment of children and young people. For example, part of the healthy child programme's work included the promotion of immunisations, smoking cessation, breastfeeding, healthy eating, and dental health.

The Islington Additional Needs and Disability Service (IANDS) had successfully delivered three parent workshops in the summer holidays as part of a pilot for the 'Talking Two's pathway'. Weight management programmes for families with children aged 2 – 11 years in Islington were delivered through the Families for Life programme. This programme included working with families on preparing healthy meals.

Across the clinics we visited we saw evidence of staff engaged in health promotion work and posters for a range of topics such as child safety, breast feeding, weaning, safer sleep, immunisations, speech and language development. Many linked with national initiatives, for example, tummy time by the British Health Foundation, We observed a health visitor given safer sleep advice to a new father during a home visit. The trust had a comprehensive website which provided information on health promotion topics.

Our observations during home visits and clinics showed that children and young people, and their families or carers, were empowered and supported to manage their own health, care and wellbeing, and that they were involved in regularly monitoring their health, where appropriate. For example, two new mothers we spoke with reported that their health visitors supported them with breastfeeding, gave advice on eating well and monitored their mood by carrying out mood assessments.

In Haringey, the Early Years Speech and Language Therapy service offered the Chatterpillars package which is a weekly speech and language therapy session combined with parent training for 10 weeks. In Islington speech and language support was also offered at a drop-in clinic at one of the community centres.

The service offered vaccinations for influenza (flu) to pregnant mothers, toddlers, children and young people.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Capacity Act (MCA) 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice. The trust had up-to-date policies regarding consent and the Mental Capacity Act (MCA) 2005 that were accessible to staff. Staff knew to assess for Gillick Competence when working with young people. Gillick Competence is a term used in medical law to decide whether a child under 16 years of age can consent to his or her own medical treatment, without the need for parental consent. Staff supported children who wished to make decisions about their treatment.

Staff considered issues of capacity, competency and consent during assessments, consultations, visits and when care and treatment was being delivered. Consent practice and records were monitored and reviewed to improve how young people were involved in making decisions about their care and treatment. Records we viewed showed that staff had sought consent before completing any treatment or procedure. We saw that consent forms had been signed and uploaded onto the electronic patient record.

The Children in Care Team in Haringey had developed a joint consent form with social care teams to cover child protection issues and to ensure that all health assessments complied with statutory requirements. In all the appointments we observed we observed staff explained and asked for verbal consent before completing any treatment or procedure.

Staff had undertaken training in the Mental Capacity Act and Deprivation of Liberty Safeguards as part of their mandatory training.

Is the service caring?

Compassionate care

Staff treated children, young people and their families with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

We spoke with 11 parents and two children. They told us that staff treated them with kindness, and with utmost respect for them as individuals.

There was a strong visible person-centered culture. Staff were highly motivated and inspired to offer care that was kind and promoted people's dignity. Staff interactions with children, young people and families we observed were professional, sensitive and appropriate at all times. Staff spoke to people in a respectful tone and with warmth, giving them enough time to understand and respond. They asked questions that showed they were taking an interest in what young people and carers were doing.

Staff ensured that the privacy and confidentiality of children and young people was respected. For example, by ensuring that doors were closed during consultations and by staff knocking on doors before entering.

The service used a range of methods to gain feedback and input from those who used the service and their parents or carers.

Emotional support

Staff provided emotional support to children, young people, families and carers to minimise their distress. They understood peoples' personal, cultural and religious needs. We observed staff provide emotional support to children, young people and families when necessary during the inspection. Family members and children we spoke with were positive about the emotional support they received.

The Parent Infant Psychology service (PIPS) in Haringey offered direct interventions to parents and infants aged 0-2 years where there was difficulty in developing the attachment relationship.

The Looked After Children nurses kept in touch with young people who were placed out of borough.

Family nurses within the Family Nurse Partnership programme offered emotional support to individual mothers in pregnancy and during their child's development.

The service provided a variety of drop-in sessions across the boroughs of Haringey and Islington to aid access to clinical advice and support. These sessions were held at child health clinics, local churches and children's centres. Staff referred parents to parent and baby groups, children's centres and drop in sessions for additional support. Health visitors also offered a drop-in service for one to one support.

In Haringey staff worked with mental health services to deliver 'KIDSTIME' workshops which supported parents, carers and children and young people from 4 - 18 years to gain support and talk about mental illness and the impact of mental illness on the family.

Parents we spoke with confirmed they knew how to contact staff between appointments.

Understanding and involvement of patients and those close to them

Staff supported and involved young people, families and carers to understand their condition and make decisions about their care and treatment. Parents and carers we spoke with during our inspection provided positive feedback about the extent to which they had been involved in their child's care.

Staff involved children and young people in their care plans as appropriate. School nurses worked in collaboration with young people to develop health education care plans.

Staff communicated with children, young people and families so that they understood their care and treatment. This included finding effective ways to communicate with children with communication difficulties, for example, one parent reported that the enuresis nurse had provided information in an accessible format for their child so that they could understand the condition better.

Nurses involved families in developing the plan of care for their child in clinic appointments we observed.

At the Child Development Centre in Haringey the service had established the Chaterpillars group which offered therapy and support to parents of children with newly diagnosed complex needs.

Within the Camden Speech and Language therapy service for children and young people therapists had developed a training programme for parents who had a newly diagnosed deaf child. Staff in this team were trained in British Sign Language.

Staff understood the emotional and social impact that a child or young person's care, treatment or condition had on their, and their families, wellbeing. Staff we spoke with explained the importance

of a holistic person-centred care model and told us they aimed to work in partnership with children and young people to gain their trust.

Children, young people and their families could give feedback on the service and their treatment and staff supported them to do this. Feedback was obtained using the Friends and Family Test. School nurses in Islington had piloted a new feedback questionnaire based on health promotion with parents. Plans were in place to use the feedback to provide more centralised training for parents.

Is the service responsive?

Planning and delivering services which meet people's needs

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care. The community children, young people and families service was commissioned separately from the trust for the London Boroughs of Camden, Hackney, Islington and Camden. As a result, there were some differences in the way services in each borough were planned and delivered. Regular meetings between commissioners and service leads considered how best to meet the local health needs within the funding available.

The Community Children's Nursing teams had clear criteria for referral to each team and clear exclusion criteria, so only children who could be cared for safely in the community were accepted by the teams. For example, the Hospital at Home Team had inclusion and exclusion criteria related to children's paediatric early warning scores and other physical health measures. For children with bronchiolitis there needed to be no smokers in the child's home and an oxygen saturation level of more than 88%.

Managers were aware of the needs of the local population, including major population groups, which included Turkish and Somali communities. In Haringey in response to the demand for speech and language therapy services in the Turkish community a Turkish speaking speech and language therapy group had been established.

In response to a high level of respiratory illness in local children the service had developed a pathway to ensure that children received the treatment and support they needed. GPs had given positive feedback about this pathway and the expertise of the nursing staff.

Staff conducted home visits before and after school to take account of the needs of working families.

Meeting the needs of people in vulnerable circumstances

The service had Looked After Children (LAC) teams who worked in collaboration with external organisations to meet the needs of children who were looked after and care leavers to improve their health outcomes. The service carried out initial health assessments and provided regular reviews until the young person's 18th birthday. A health passport was completed and given to the young person with a copy of their personal health plan.

The service had systems to care for children and young people in need of additional support and specialist intervention. For example, children and young people diagnosed with autism were supported to create an 'All about me' book. This provided important and useful information about the person, details of any multidisciplinary team members involved in their care, medicines prescribed, individual health needs and communication needs. Teams used social stories where appropriate to help teach social skills to children and young people with autism. Social stories are

short descriptions of a particular activity, situation or event and what to expect in that situation and why. The speech and language and autism support team ran training sessions for staff on how to create these stories.

Staff made sure young people, families and carers could get help from interpreters or signers when needed. An interpreting service was available for people for whom English was not their first language. Information leaflets were available in the main languages spoken by the local community. Leaflets could be requested in other languages. More than 100 languages were spoken in the local community.

Staff were aware of community organisations that could support families experiencing a range of difficulties. For example, a local service providing help with housing problems. Staff signposted people to an air quality online application, which helped families plan walking safer routes to school if a child suffered from asthma.

The Michael Palin Centre offered specialist services to children and young people who stammered. The service provided individually tailored treatment programmes for these children and young people.

Access to the right care at the right time

The largest ethnic minority group within the trust catchment area is 'other white (including Turkish)' with 17% of the population.

	Ethnic minority group	**Percentage of catchment population (if known)**
First largest	Other white (including Turkish)	17.0%
Second largest	Black African	6.0%
Third largest	White Irish	4.5%
Fourth largest	Black Caribbean	4.0%

(Source: Universal Routine Provider Information Request – P48 Accessibility)

The trust identified six community healthcare services for children and young people for which 'referral to initial assessment' and 'assessment to treatment' times were measured against targets.

The trust met the referral to assessment target for all six targets listed.

The trust did not provide information about the number of days from assessment to treatment.

Name of hospital site or location	**Name of team**	**Service Type**	**Days from referral to initial assessment**	
			National / Local Target	**Actual (median)**
Whittington Hospital	Child Development Services	Community	84	49
Whittington Hospital	Community Children's Nursing	Community	14	0
Whittington Hospital	Community Paediatrics Services	Community	126	63

Whittington Hospital	Health Visiting	Community	14	10
Whittington Hospital	Looked After Children	Community	24	20
Whittington Hospital	School Nursing	Community	84	6

(Source: CHS Routine Provider Information Request – CHS10 Referrals)

The service monitored waiting times. At our previous inspection we recommended that the trust should meet its published targets for access to the service. At this inspection, whilst we found many improvements, the service was working in a challenging environment; in some areas the rate of referrals had increased by more than 50%. This had had an impact on the speed at which young people could be seen by some teams.

We found that waiting times for the parent infant psychology service had improved. The average waiting time for this service was 3.5 weeks compared to the trust target of 12 weeks.

The service was facing challenges in its autism pathway. In Haringey for the period July 2019 to September 2019 the waiting time for the community paediatric autism diagnosis service was 47.5 weeks and in Islington it was 30 weeks compared to the trust target of 18 weeks. Both teams reported a high number of referrals being received and described the actions they were talking to respond. For example, in Haringey the team had proactively changed its diagnostic pathway. Previously, paediatricians led on assessments. The service was now moving to a model of therapist-led assessments. Four speech and language therapists had been trained to complete the Autism Diagnostic Observation Schedule (ADOS). Speech and language therapists ran social communication groups for small groups of families. At the end of the six appointments, the therapists could provide a diagnosis, if appropriate, for the children involved. These staff were supervised by a new social communication team lead. The service had also introduced a one-off workshop for parents of children on the waiting list to provide them with information and to signpost to other services. In Islington, the team had secured funding to keep a speech and language therapist trained in ADOS for another year.

The Early Years speech and language therapy service in Haringey had a12-week average wait for assessments compared to the trust target of 13 weeks. The service had seen an increase in the number of referrals and in response, the team had introduced a telephone referral assessment. The team were reviewing the model of delivery and were working with commissioners to implement changes from 2020.

Both heads of service reported that they were working closely with commissioners to ensure that they could meet the additional demand safely.

Managers monitored and took action to review children young people and families who ‘did not attend’ (DNA) appointments. Staff recorded all missed appointments on the electronic patient record system to enable them to follow up. Where appropriate staff raised a safeguarding concern where missed appointments involved high risk, such as new mothers.

Learning from complaints and concerns

From August 2018 to July 2019 the trust received seven complaints about community services for children, young people and families (2.2% of total complaints received by the trust).

A breakdown of complaints by subject and site is shown below:

Community children, young people and families total complaints

Type of complaint	Number of complaints	Percentage of total
Cancellation of an appointment	1	14.3%
Delay in being seen for appointment	1	14.3%
In regard to process	1	14.3%
Inconsiderate/Uncaring/Dismissive	1	14.3%
Lack of information to relatives	1	14.3%
Poor Communication /Lack of, between Professionals/Patients	1	14.3%
Sharp/Harsh/Abrupt	1	14.3%
Total	**7**	**100.0%**

Three of the seven complaints (42.9%) in this core service were about bladder and bowel care services.

(Source: Universal Routine Provider Information Request (RPIR) – Complaints tab)

The service treated concerns and complaints seriously, investigated them and learned lessons from the results. Staff knew how to handle complaints and supported children, young people and their families to follow the complaints procedure. Information about making complaints was available on the trust website, in information packs and displayed throughout the locations we visited.

Team managers received support to deal with complaints in line with the trust's policy. They said that if there were learning points from a complaint they discussed these with the individual staff member concerned or the whole team as appropriate.

When children, young people and families complained or raised concerns, they received feedback. Complaint responses included full details of the findings of any investigation and the reasons why the complaint had been upheld or not upheld.

From August 2018 to July 2019 the trust received nine compliments for community services for children, young people and families, which accounted for 2.5% of all compliments received by the trust.

(Source: Universal Routine Provider Information Request (RPIR) – Compliments tab)

Is the service well-led?

Leadership

Leaders at all levels had the right skills, knowledge and experience required to deliver high quality and sustainable care. Leaders had a good understanding of local issues and the needs of the diverse local population, as well as the challenges and priorities in their service and they

proactively sought to address them. They worked collaboratively with partner organisations, stakeholders and other agencies to deliver high-quality child and family centred care.

The senior managers were very visible within the service and could describe how the quality of care was being maintained and improved. Staff said managers encouraged them to raise any concerns and they provided support when required. All staff we spoke with consistently told us they were confident to raise issues with local managers and senior leadership.

All managers and staff had access to leadership development training at various levels.

Vision and strategy

The trust's senior leadership team had successfully communicated the trust's vision and values and staff knew how they were applied to the work of their team. Staff understood the trust's values of innovation, compassion, accountability, respect and excellence. They described how these related to their work within the organisation and to the trust's broader vision and strategy. Staff we spoke with told us they felt very much part of the trust, despite being spread geographically across the three boroughs.

Culture

The culture of the service was centred on the needs of children, young people and families. Leaders promoted a culture within the trust which was open, honest and responsive. This was reflected in how the service managed the many challenging situations they faced. At all levels within the service leaders spoke openly about where improvements were needed and how they were working to address them, for example, challenges in recruiting health visitors and school nursing staff, waiting times for autism diagnosis and speech and language services.

Staff told us they enjoyed working for the organisation, they spoke positively and proudly about their work, teams and senior leadership. They reported that there was no blame culture and incidents were seen as an opportunity to learn and make improvements. Staff knew about whistleblowing procedures and said they would feel able to raise any concerns without fear of retribution. No staff reported bullying or harassment in the teams we inspected. Staff were aware of the freedom to speak up guardian and how to contact them.

Teams worked well together and where there were difficulties managers dealt with them appropriately.

Managers ensured that staff had opportunities for learning, development of skills and knowledge and time to undertake specialist training for their roles. Nursing, therapy and medical staff accessed clinical networks and forums within the trust.

Managers reviewed staff performance through supervision, appraisals and audits. Managers took the necessary action to deal with any competency issues.

Measures were in place to protect the safety of staff who worked alone in the community. The trust had a lone working policy and procedure in place. Individual teams had also developed local systems to support staff carrying out home visits, these included a buddying system for reporting back to the team when visits finished after 5pm. All home visits were risk assessed. In the children's community nursing teams staff carried personal alarms and there were systems in place to keep in touch with on-call managers out of hours.

Leaders reported examples of initiatives to promote staff health and wellbeing, for example staff could get discounted gym membership, access to mindfulness, counselling and keep fit.

Psychological support and supervision were available to staff when needed. Staff could access the trust employee assistance programme, where they could obtain advice on a variety of matters such as legal, financial, health and housing.

The trust had processes to ensure the duty of candour was met. Staff understood the duty of candour and confirmed they were encouraged to be open and honest. Staff had received training in the duty of candour and there was a prompt on the electronic incident reporting system to remind staff.

Governance

There were effective governance structures, processes and systems of accountability to support the delivery of good quality services and ensure high standards of care. However, these were less firmly embedded at the Northern Health Centre where there were areas of improvement required with record audits, medicines management, equipment servicing, monitoring staff supervision and competency checks. A new matron was in post and this gave them the opportunity to address these issues. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service. The borough leads reported up through the quality and safety group to the integrated care support unit board and from there to the quality committee, a sub-committee of the trust board. The trust board received the minutes of the quality committee so both achievements and concerns were reported to the board. Managers reported that the structures worked well and ensured key information travelled effectively from floor to board and vice versa.

Management of risk, issues and performance

There were arrangements for identifying, recording and managing risks. Staff used an electronic incident reporting to identify risks. Teams maintained local risk registers which fed into the children and young people integrated clinical service unit (ICSU) service risk register. Managers were aware of the main risks in their service and associated teams. For each item on the risk register there were identified actions to mitigate the risk.

The teams had access to robust management information. This was presented to show trends in service delivery over time which they could use to inform their work. The same information also provided clear information to the directorate and board. Various key performance indicators (KPIs) were measured to gauge the performance of the service. These were reported to Public Health England and local commissioners, and covered areas such as waiting times, referrals, safeguarding, looked after care reviews, new born visits and school nursing mandated targets. The service worked well with external stakeholders including commissioners to address service demands.

Information management

The service collected, analysed, managed and used information well to support all its activities, using secure electronic systems with security safeguards.

Most teams reported that the information technology infrastructure, including the telephone system, worked well. Where there were issues these were escalated via team managers and borough leads. Speech and language therapy staff in Camden reported that whilst there were improvements with equipment they still experienced connectivity issues and this effected their mobile working.

Staff described using social media to connect and share ideas (but not confidential information). Various professional groups had their own messaging group.

Information governance training was mandatory for all staff. Trust policies and procedures were available for all staff and accessible via the trust intranet.

Staff had access to up-to-date accurate information on young peoples' care and treatment. Staff were aware of how to use and store confidential information.

Team managers had access to live information to support them with their management role. This included information on the performance of the service. For example, waiting times, incidents, accidents, staffing, training and appraisals. Information provided to them was accessible, timely, accurate and identified areas for improvement.

Staff made notifications to external bodies as needed. For example, the service notified the local authority of safeguarding concerns.

Engagement

The service engaged well with staff, children and young people and their families to obtain feedback about the service and make improvements. Feedback was received through the Friends and Family Test, feedback cards at the various clinics and through direct feedback.

In Haringey school nurses were piloting a new feedback form for parents to complete.

In response to feedback from parents, school nurses attended a coffee morning for parents and delivered a session on accident prevention.

At the Northern Health Centre a group of young people were invited to carry out a 15 steps walk around. They provided feedback to the service which resulted in more young person-friendly leaflets and information being made available.

The service was working collaboratively with the organisation Ambitious about Autism to carry out a review of complaints and incidents involving autistic patients across the Whittington Health NHS Trust, as well as commissioning surveys of autistic people, their families and healthcare professionals to better understand how to improve patient and staff experience.

The service was in the process of setting up a children and young persons' forum.

Children, young people and families had access to up-to-date information about the work of the trust through regular news items on the trust's website.

Staff had access to a monthly staff newsletter that shared service updates, quality and safety guidance and good news stories. Teams held awaydays twice a year to aid their development.

The trust celebrated success through a staff awards scheme. Staff were able to nominate individuals and teams for outstanding performance.

The trust engaged with staff and provided activities and initiatives to support their health and well-being. For example, fitness classes, pregnancy yoga and a menopause clinic.

Leaders engaged effectively with external stakeholders. For example, in Haringey commissioners and managers were working together to find solutions to the lack of specialist health visiting and school nursing staff.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. All the teams we visited had a good culture of identifying areas for improvement and trying to make changes. Staff we spoke with told us the trust gave them the freedom and support to make services changes to improve care for children, young people and their families.

Staff were able to give examples of new initiatives within the service. In Haringey speech and language therapists had developed the Language Train Model, which enabled children identified with developmental language disorder to receive additional speech and language therapy within the child's mainstream school. The team worked closely with parents and school teaching staff. The dieticians at the Child Development Centre were just about to begin a pilot (from January – July 2020) to support overweight children with learning disabilities. They had identified that this group did not receive specialist support.

Staff across the service were involved in quality improvement (QI) projects in order to improve service delivery. For example, in the Early Years speech and language therapy team the group admin project helped to reduce the amount of time taken to complete group session notes. In Camden, speech and language therapists within the deaf team had reduced clinic administration time by implementing the Ready Steady Sign project. Staff reported that they had received training in the QI approach and it was becoming embedded in practice.

The children and young people asthma team won the Nursing Times respiratory nursing award for their collaborative work to make schools in Islington more asthma friendly.

The Camden Early Years Speech and Language Therapy service was encouraging parents to have 'tech-free time' with their children. The team had produced a video which was on the trust website encouraging parents to chat with their children.

The service participated in research projects. The parent infant psychology service in Haringey was being considered for involvement in a research project looking at the experience of fathers and their adjustment to parenthood. This was in conjunction with Anglia Ruskin and Westminster universities.

Mental health services

Specialist community mental health services for children and young people

Facts and data about this service

The community child and adolescent mental health services (CAMHS) provide care and treatment to children from birth to eighteen years old and their families living in the London borough of Islington. A clinical service is also provided to mothers during the antenatal and postnatal period if they are experiencing mental health problems that impact on their capacity to parent.

The service works with colleagues in children's social care, family centres and primary and secondary schools to train and support them in the identification of children with mental health problems. Clinical interventions include parent work (individual and group), cognitive behaviour therapy, systemic family psychotherapy, art therapy, psychotherapy and educational psychotherapy. The service operates from 9am to 5pm Monday to Friday (excluding bank holidays). People using the service could access psychiatric support out of hours when needed.

Since September 2019, the service has partnered with other local statutory and independent sector organisations to provide an integrated care model known as the Social Emotional Mental Health (SEMH) service. The SEMH uses a stepped care model to provide targeted support and preventative interventions in the local community. Through one central point of access, patients and their families can access established mental health services and innovative social and emotional interventions depending on their level of need.

There are seven main teams within the community CAMHS service specialising in intake, adolescent assessment and outreach, psychological therapies, neurodevelopment, early years, schools and early help, transition to adult services and social care and welfare. The teams work in a variety of settings including schools, community buildings and shared hubs with the local authority and other organisations. The central base for the mental health component of SEMH was the Northern Health Centre.

On this inspection we only inspected those parts of the SEMH service which are managed by the trust.

Is the service safe?

Safe and clean environment

Teams delivered services across the community in a variety of settings including schools, community buildings and shared hubs with the local authority and other organisations. We visited the services' central base at the Northern Health Centre and found all areas where young people

received care and support were safe clean, well equipped, well furnished, well maintained and fit for purpose.

The service was based on the third floor of the health centre accessed via a main stairwell and lift. A security gate was in place to ensure visitors were not able to enter without staff knowing. Clinical equipment and office space were behind locked doors that required a security key card to access.

Staff completed and regularly updated risk assessments of all areas and removed or reduced any risks they identified. The service had recently refitted a visitor bathroom with anti-ligature features to make it safer for use by young people who posed higher risks. All interview rooms had alarms and staff available to respond.

Staff made sure equipment they used was well maintained, clean and in working order. Clinic rooms had the necessary equipment for young people to have physical examinations. A first aid kit was available to staff and included ligature cutters.

Staff and young people said they felt safe and that the environment was well maintained. The service had acted on feedback received by young people to improve the waiting rooms and clinic rooms used for appointments, this included redecorating and replacing chairs in the waiting room.

Staff made sure cleaning records were up-to-date and the premises were clean. Infection control guidelines were followed by staff in the service and there was access to handwashing facilities.

Where the service shared space with other agencies staff ensured the environment was safe to deliver support.

Safe staffing

The service had enough staff, who knew the young people and received basic training to keep them safe from avoidable harm. Managers calculated safe staffing levels and planned the number and grade of staff within teams to ensure they could deliver effective services. The service had ensured it had enough psychologists, family therapists and psychotherapists to deliver a range of psychology-based therapies. The service had enough nursing, medical and other allied health professionals available to ensure young people's wider needs, including physical health, were met.

The number of young people on the caseload of the teams was not too high to prevent staff from giving each patient the time they needed. However, the recent launch of the new SEMH integrated model of care meant some staff had needed to provide extra support to non-clinical colleagues in partner organisations. Some members of staff had faced challenges in meeting their full schedule of work because of this initial disruption. Managers were aware of this and were working to determine workstream priorities within teams and ensure staff were provided with support.

The table below shows the breakdown of whole-time equivalent (WTE) staff in post in this core service from September 2018 to August 2019.

Annual staffing metrics

	Core service annual staffing metrics						
	September 2018 to August 2019						
Staff group	**Annual average establishment**	**Annual vacancy rate**	**Annual turnover rate**	**Annual sickness rate**	**Annual bank hours (% of available hours)**	**Annual agency hours (% of available hours)**	**Annual unfilled hours (% of available hours)**

All staff	77.9	-15%	24%	13.0%			
Qualified nurses	6.0	23%	29%	2.7%	Not provided[1]		
Nursing assistants	5.6	-37%	80%	19.3%	Not provided[1]		
Medical staff	3.3	53%	38%	0.0%	392 (7%)	557 (10%)	35 (1%)
Allied health professionals[2]	51.7	-22%	0%	18.4%			

1 A breakdown of bank and agency usage for this specific service was not provided as staff were reported as part of the trust-wide community services data.

2 The trust was not requested to provide bank and agency usage for this staff group.

The service had oversight of vacancies and managed them well. Information the trust used as part of their contract monitoring showed an overall vacancy rate of two percent in September 2019. Some teams had higher vacancy and turnover rate than others. The main reason for this was the number of trainee positions within different teams; the service was effective in supporting trainees to progress in their roles which created natural turnover.

When staff vacancies added pressure to an individual team's capacity managers were aware of the issue and offered extra support to staff whilst they worked to recruit into these unfilled posts. For example, the Adolescent Outreach Team were still able to deliver patient follow ups within their seven-day target but, due to vacancies within the team, had felt stretched to manage long-term intensive work as well. The service had received additional funding from NHS England to address historic backlogs in waiting lists and had employed three members of agency staff for a limited period.

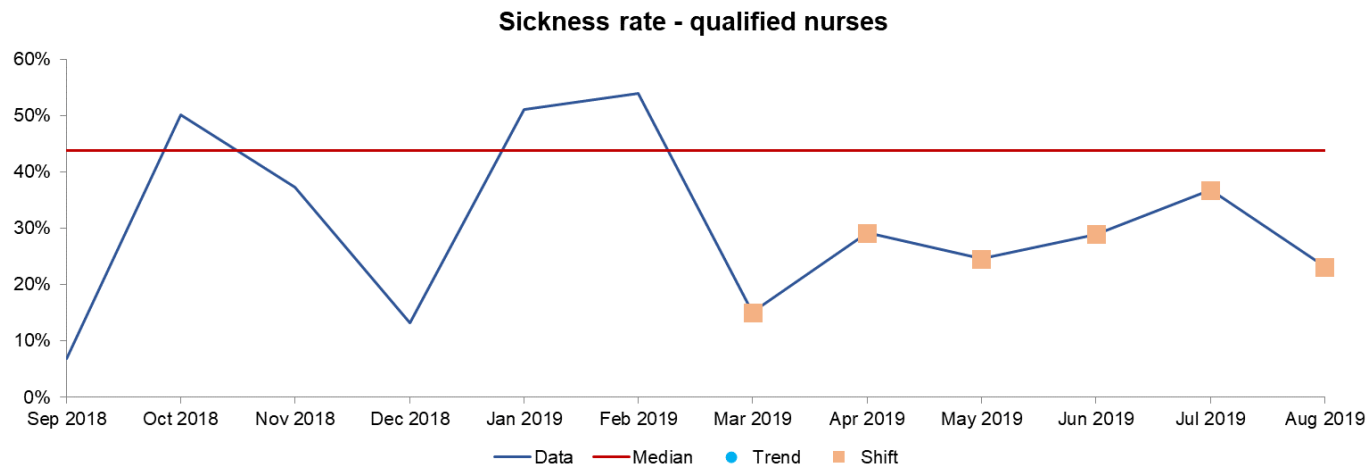
The service had enough medical staff and could get support from a psychiatrist quickly when needed. Following a consultation and change in staffing structure, psychiatrists were now embedded into teams across the service. At the time of our inspection the service was looking to recruit a specialist doctor to provide additional medical support to teams and widen the service's physical health care offer.

Managers could use locums when they needed additional support or to cover staff sickness or absence. The service had worked with local commissioners to address the attention deficit hyperactivity disorder (ADHD) waiting list using locums and the waiting list had decreased as a result. Managers made sure all locum staff had a full induction and understood the service. Staffing figures for the past 12 months showed no indications of deterioration or change for the use of agency medical staff.

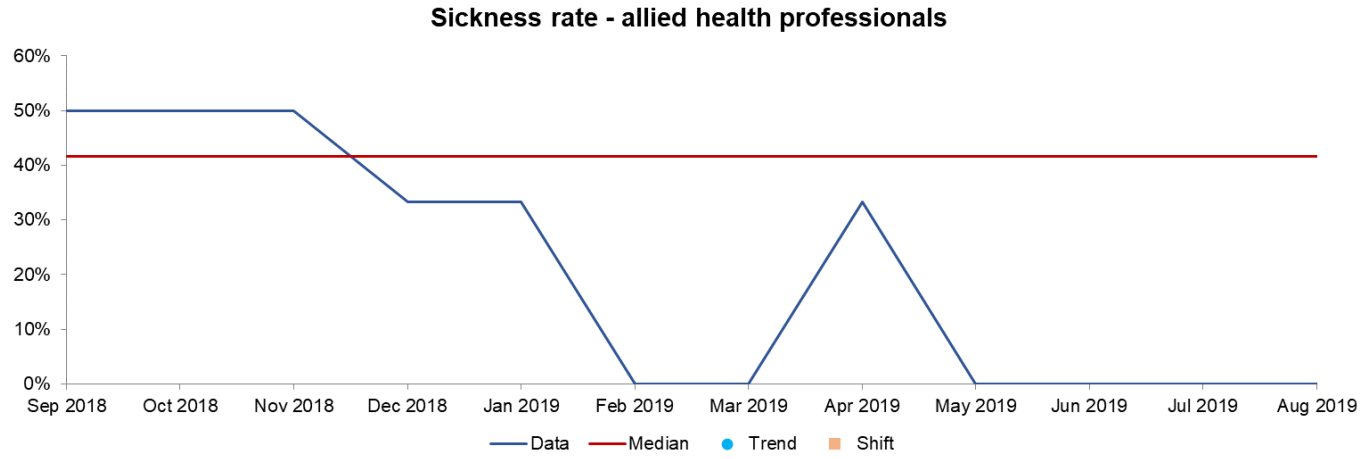
Sickness rates

Managers were able to cover staff sickness and absence using bank and agency staff. Only staff who were familiar with and understood the service were used. Managers could access central advice and guidance to assist them with managing staff ill-health.

Staffing figures for the past 12 months showed no indications of deterioration or change for the vacancy and sickness rates of nurses. Some members of nursing staff were on long-term absence from the service due to sickness and other personal reasons. Due to the relative low number of nursing posts across the service this meant that the overall sickness rate was disproportionally affected by these individual staff absences.



Monthly sickness rates over the last 12 months for allied health professionals had stabilised since April 2019. When we discussed this with senior managers and clinicians they felt that the recent positive change in the leadership structure had contributed to this.



Mandatory training

The trust had a mandatory training programme that was comprehensive and addressed the needs of young people and staff. Staff had completed and kept up-to-date with their mandatory training. Managers monitored compliance and alerted staff when they needed to update their training. Staff were able to easily access mandatory training and managers allowed time for them to complete it.

The trust set a target of 90% for completion of mandatory and statutory training. The compliance for mandatory and statutory training courses at 31 August 2019 was 89%.

Staff members who were on long term secondment or sick leave had been included in this data, which meant that actual compliance was likely to be better than stated for some courses. The service manager noted the accuracy of the data needed some improving and had discussed this with the central information team within the trust.

Key:

Met trust target	Not met trust target	Higher	No change	Lower
✓	✗	↑	→	↓

Training Module	Number of eligible staff	Number of staff trained	YTD Compliance (%)	Trust Target Met
Safeguarding adults level 1	104	104	100%	✓
Safeguarding children level 1	7	7	100%	✓
Health and safety	99	104	95%	✓
Risk management / duty of candour	98	104	94%	✓
Equality and diversity	96	104	92%	✓
Infection prevention and control	96	104	92%	✓
Fire safety	93	104	89%	✗
Information governance	92	104	88%	✗
Safeguarding children level 3	59	67	88%	✗
Moving and handling	88	104	85%	✗
Conflict resolution	43	52	83%	✗
Safeguarding adults level 2	78	97	80%	✗
Safeguarding children level 2	23	30	77%	✗
Resuscitation	67	89	75%	✗
Total	**1043**	**1174**	**89%**	✗

Assessing and managing risk to patients and staff

Assessment of patient risk

Staff completed risk assessments and reviewed these regularly, including after any incident**.** All young people were assessed for risk at or soon after referral and triaged to services appropriate for their needs. If young people were referred to other teams within CAMHS further risk assessments using a risk assessment tool may be completed depending on the patient's individual needs. The assessments and associated risk management plans were written in the progress notes section of the electronic patient record system. This meant that they were accessible for relevant staff, but any themes or trends were hard to analyse as the risk assessment module in the trust's electronic patient record system was not tailored for CAMHS, so it could not be routinely used.

The service had improved since our last inspection and ensured that patient risk assessments and management plans were reviewed and updated following risk incidents. Young people that posed higher risk had detailed risk assessments, formulation and management plans in place. We did

find one discrepancy in the level of risk assigned to the same patient after being assessed by two different teams within CAMHS. This was raised with staff on our inspection and they took steps to address the issue.

From discussions with staff it was apparent that the service was very mindful of each young person's level of risk and this was discussed regularly in supervision, team and clinical meeting. The service was proactive in working with other agencies to assess risks related to the whole family and not just the young person and making sure that clinicians were made aware of these risks.

Management of patient risk

Staff recognised when to develop and use crisis plans and advanced decisions according to patient need. Young people were offered an out of hours telephone support line where appropriate. The service ensured young people with higher risks had crisis plans in place and worked with liaison teams in emergency departments if they thought it was likely the patient may present there.

Staff responded promptly to any sudden deterioration in a young person's health. The Adolescent Assessment and Outreach Team (AAOT) was specialised in delivering support for young people in crisis. They consistently met the target of responding to urgent referrals within five working days and monitored young people on waiting lists for changes in their level of risk and responded when risk increased. The service maintained close links with local inpatient CAMHS units in case young people's needs increased and they required treatment in hospital. The team also worked with the CAMHS inpatient units to facilitate discharges for young people as early as possible and provided community-based support to avoid future admissions.

Although the service was not operational at weekends, managers worked with a paediatric mental health liaison team that was based on the paediatric ward in the main acute hospital and would accept emergency admissions from the emergency department.

Staff kept themselves safe whilst working in the community. They followed clear personal safety protocols when lone working and discussed any changes to these protocols during team meetings. There was always a senior clinician on duty and staff were able to access support when they needed it. Any incidents that compromised staff safety were reported and reviewed so appropriate support could be offered to staff and lessons learnt shared with the wider team.

Safeguarding

Staff knew how to recognise adults and children at risk of or suffering harm and worked with other agencies to protect them. All referrals were screened for safeguarding concerns by the local social services team at the central point of access to the new SEMH service. Staff could give examples of how to protect young people from harassment and discrimination, including those with protected characteristics under the Equality Act. The service was aware of culturally linked safeguarding concerns in the local area and had a clear policy on Female genital mutilation that provided staff with advice and guidance on how to handle such concerns.

Staff had training on how to recognise and report abuse, and they knew how to apply it. As part of this external experts attended team meetings and awaydays to talk about specific safeguarding concerns within the local area, this included domestic abuse, knife crime and other issues. Managers ensured that staff kept up to date and accessed refresher training on safeguarding.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. For example, if young children did not attend appointments and the team had concerns regarding parental engagement they were pro-active in raising these concerns with social services and addressing them in a coordinated way.

Although the service made safeguarding referrals they did not keep an independent record of the number of referrals that had been made by each team to the local authority. This was to avoid duplication of responsibilities within the integrated service structure, particularly where CAMHS teams were co-located with teams from the local authority's social services. Instead managers from CAMHS teams received regular data from the local authority to monitor the overall number of referrals, identify trends and manage the quality of information included in referrals. Staff received safeguarding supervision for which records were kept and the trust's central safeguarding team was accessible and visible to assist with any queries.

There were no serious case reviews that commenced or were published in the last 12 months (September 2018 to August 2019) that relate to this service. There were systems and processes in place to ensure lessons learnt from serious incidents that took place in the wider trust were shared with teams within CAMHS and changes were made when relevant.

Staff access to essential information

Staff kept detailed records of young people's care and treatment. Records were clear, up-to-date and easily available to all staff providing care. We reviewed the records of nine young people during out inspection and found the quality of record keeping allowed staff to access the information they needed to deliver care and treatment. There had been recent improvements and investments in technology to increase connectivity to the electronic patient record system in the community. However, some staff mentioned that it remained a challenge in non-healthcare locations. Senior managers were aware of this and were continuing to work to resolve these challenges.

All records were stored securely on the services electronic record keeping system. Notifications and information were shared amongst different teams and external organisations in a way that protected the confidentiality of young people and their families. If any incidences relating to information governance occurred the service was quick to report this, investigate and learn from it.

Staff appropriately shared information about young people and any changes in their care, including during transfer of care between services. The same recording system was used across the community CAMHS service and the wider trust which meant that information could be easily shared.

However, when sharing information between partner organisations in the SEMH service, some team members had to work across multiple electronic record systems. This had caused some challenges for staff when accessing and transferring information between systems. More work was required to improve the interoperability of these systems to make efficient use of staff time and reduce the risk of inconsistency and errors when transferring information between the different systems. Managers were aware of these issues and had provided short-term solutions to minimise any potential impact.

Medicines management

The service used systems and processes to safely prescribe and record medicines. Staff stored prescribing documents in line with the provider's policy. The service did not store medicines on

site. All medication prescribed by the service was subsequently co-managed with the young person's local GP.

Staff members worked with GPs to ensure the effects of each young person's medicines on their physical health and mental health was reviewed according to national guidance. Systems were also in place to ensure staff knew about safety alerts and updates to national guidance so that young people received their medicines safely.

The service had medicines leaflets available in multiple languages to suit the age range of young people, these were also available on their webpage for young people to access and download.

Decision making processes were in place to ensure young people's behaviour was not controlled by excessive and inappropriate use of medicines.

Track record on safety

The service had a good track record on safety. Between October 2018 and September 2019 there were no serious incidents or never events within the service. A 'never event' is classified as a wholly preventable serious incident that should not happen if the available preventative measures are in place.

In the last two years (November 2017 to October 2019), there had been two 'prevention of future death' reports sent to Whittington Health NHS Trust. Although neither of these related to this service CAMHS staff members were aware of lessons learnt from these reports.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them clearly using an electronic reporting system in line with trust policy. The incident reporting system meant that issues were identified and addressed quickly and openly.

Managers investigated these incidents thoroughly and, where appropriate, young people and their families were involved in these investigations. We reviewed a sample of the most recent incidents reported across the service and found the quality of incident reports was good. Managers analysed these incidents to identify what went wrong and any identify themes and trends.

Staff understood the duty of candour. They were open and transparent and gave young people and families a full explanation if things went wrong. The incidents we reviewed demonstrated that staff had apologised and had given young people honest information and suitable support to regain trust in the service. Staff met to discuss the feedback from incidents and look at improvements that could be made. For example, in response to a recent incident regarding information governance managers now regularly shared best practice about information governance during team meetings.

Between October 2018 and September 2019 there were no serious incidents reported by this service. However, managers debriefed, and supported staff affected by any serious incident that had happened externally.

In the last two years (November 2017 to October 2019), there had been two 'prevention of future death' reports sent to Whittington Health NHS Trust by the coroner. Neither of these related to this service but staff were aware of lessons learnt where they were applicable to community CAMHS.

Is the service effective?

Assessment of needs and planning of care

The extent of the assessment and care planning process was proportionate to the needs of individual young people. The Intake team triaged all referrals made to the new Social Emotional Mental Health (SEMH) service with partner organisations, who also screened referrals for safeguarding concerns. From the initial joint-assessment a decision was made about which service would best meet the young person's needs. The collaborative assessment and triage process meant people who did not meet the threshold for specialist treatment from the Whittington's community child and adolescent mental health service (CAMHS), could access other forms of support.

When young people were referred to specialist CAMHS teams further, more detailed assessments using psychological formulation were completed. For example, the Neurodevelopmental Team completed detailed family-centred assessments for young people with possible autistic spectrum conditions. These assessments took place over a longer period in a variety of settings, with input from the multi-disciplinary team and teachers.

Care plans were created in partnership with young people and their families that reflected the assessed needs. We reviewed the records of nine young people and found all care plans were personalised, holistic and recovery-oriented. Care plans were written in a way that made them understandable to young people. Staff regularly reviewed and updated care plans when young people's needs, or risk factors, changed.

Staff understood young people's physical health problems and worked closely with GPs and other professionals to ensure young people's physical health needs were met. Information was shared appropriately between professionals to avoid young people repeating the same information to different clinicians and to streamline the assessment process.

Best practice in treatment and care

Teams from the community CAMHS provided targeted support and preventative interventions in conjunction with other local organisations through the new integrated SEMH service. Using a stepped approach to care and support, young people could access a variety of services dependent on their needs.

Each team had a well-defined purpose and collectively they were able to offer a wide range of treatment and care options to meet the needs of young people and their families. The Central Therapies team used psychological-based interventions such as cognitive behaviour therapy and psychotherapy to support young people and their families. For young people with complex needs, particularly those in crisis, the Adolescent Assessment and Outreach team provided specialist support and the Neurodevelopmental Team was well equipped to provide specialist support to young people with neurodevelopmental conditions.

A team of child wellbeing practitioners delivered lower-intensity group sessions for young people and parents to self-manage behaviours associated with anxiety and low mood. Young people aged under five were supported by an Early Years team and a Schools team was in place to provide support in tandem with educational professionals across the community. As well as completing initial assessments and triaging referrals the CAMHS Intake team was also able to offer short-term interventions to provide immediate support to young people in crisis. In addition, the Social Care and Welfare team worked alongside CAMHS to support the wellbeing of looked

after children and provide intensive support for families to prevent young people being taken into care. This service was not inspected as it was not managed by the trust.

Staff supported young people and their families to live healthier lives and provided preventive support. For example, the parent and baby service provided early intervention programmes targeting parents of children aged two and under. Clinicians worked with parents to educate them on how to better support the overall health and wellbeing of themselves and their children. The team had been proactive in working with commissioners to invest in this service, having recognised the positive impact that support for younger children and their parents had on their physical and mental health in later life. The service had received national recognition for this work.

Teams across CAMHS delivered care and treatment in line with best practice and national guidance. Staff used clinical audits to ensure they delivered effective treatment, used evidence-based interventions and met local commissioning priorities. Any learning identified from these audits was used to develop the service. The service used guidelines from the National Institute of Health and Care Excellence and materials developed by local universities to ensure they delivered locally relevant, evidence-based approaches to care and treatment.

Staff used outcome measures to assess and record the severity of patient conditions and any progress made through care and treatment. CAMHS clinicians worked with young people and their families to complete recognised outcome measures to track their progress towards their individual care goals. Collected outcomes measures were reported to commissioners, discussed in team meetings and shared on team awaydays to identify and share best practice.

Skilled staff to deliver care

Managers made sure staff had the right skills, qualifications and experience, including bank and agency staff. This staff of this service were predominantly from the psychological professions. Teams across the service included, or had access to, the full range of specialists required to meet the needs of young people under their care. The service was well resourced to deliver psychologically-based interventions and the multi-disciplinary team included psychologists, children's wellbeing practitioners, counsellors and other specialist therapists and psychotherapists. Other health professionals, including consultant psychiatrists, nurses and occupational therapists, were available to young people and their families.

Staff were supported with appraisals, supervision and opportunities to update and further develop their skills. Staff accessed multiple training opportunities within the trust and through other external avenues. For example, the lead clinician for attention deficit hyperactivity disorder (ADHD) regularly attended conferences to keep up to date with current best practice. Some senior clinicians delivered training at local universities and a national centre for children and families and had a wealth of knowledge and experience.

All new staff were supported by managers. They received an induction and had access to ongoing training. Managers valued the input of staff at the early stages of their career and ensured trainees received opportunities to develop their skills and share their ideas. Staff in development positions said they felt included in teams, appreciated and were encouraged to share their ideas as part of service development. The children's wellbeing practitioners said they had been well supported and given opportunities to practice and develop the skills they learnt whilst completing a university diploma as part of their development.

All staff attended regular team meetings and information was shared with those who could not attend. Meetings between individual teams, service clusters and the whole service took place on a

regular basis. All staff knew what was happening within the service, had received updates relevant to their role and had a understood the challenges and achievements of the wider service. External speakers sometimes attended team meetings to connect teams with the wider local area and discuss local issues such as domestic abuse and violence.

Managers supported staff to develop through yearly constructive appraisals of their work. From October 2018 to September 2019, the overall appraisal rate for non-medical staff was 77.8% and for medical staff was 83.3%. This was an improvement on the previous year but was below the trust's own target rate of 90%. Some teams had lower appraisal rates than others due to vacancies and higher turnover of staff. The associate director was working to improve appraisal completion and monitor individual teams' compliance.

Team name	Total number of permanent non-medical staff requiring an appraisal	Total number of permanent non-medical staff who have had an appraisal	% appraisals October 2018 – September 2019	% appraisals (previous year April 2018 - March 2019)
Community CAMHS	70	56	80.0%	67.6%
CAMHS Outreach Service	11	7	63.6%	70.0%
Core service total	81	63	77.8%	67.9%
Trust wide	3,118	2,313	**74.2%**	**72.8%**

All staff received regular constructive clinical supervision of their work. The frequency of supervision depended on each staff member's level of experience, with less experienced staff receiving it more frequently. Between September 2018 and August 2019, the average rate of supervision across all six teams in this service was 96.6%. Some teams showed lower rates of supervision due to staff vacancies and long-term sickness. Opportunities for reflective practice were well embedded within teams and data supplied by the trust showed 100% of expected educational supervision meetings were carried out in July 2019.

Multidisciplinary and interagency team work

Staff from different disciplines worked together as a team to benefit young people and make sure they had no gaps in their care. Young people received coordinated support from a range of experienced clinicians that included professionals external to the service. Some staff members worked across multiple teams within CAMHS which allowed for the cross-fertilisation of ideas and sharing of expertise. For example, a clinician with specific knowledge of eating disorders worked to provide specific insight for young people across the different CAMHS teams. The teams also worked well with health visitors and paediatricians and had developed strong links with paediatric mental health teams at two accident and emergency departments.

Staff held regular multidisciplinary meetings to discuss young people and improve their care. Where young people with complex needs had been admitted to inpatient services, the service worked with partners across the care system to develop discharge and transfer plans. We observed a multi-agency meeting between CAMHS clinicians, NHS commissioners, educational professionals and young people and their families that showcased excellent multi-agency oversight of the process, including risk management.

The service was exceptional at working in partnership with external organisations to deliver support and treatment. Professionals from across the care pathways worked together to provide a range of integrated support options for young people including through the new integrated Social, Emotional and Mental Health (SEMH) service. Staff were passionate about providing early interventions for young people and their families and had cascaded a trauma-informed approach to local partners through training and awareness raising events. A named CAMHS clinician was allocated to all local schools and pupil referral units to support pupils and work with other services to address wider local issues such as adolescent knife crime. Regular meetings took place to ensure professionals from different agencies remained connected and worked in a joined-up way.

As the SEMH service had only been launched in September 2019 certain aspects of the integrated model were still being refined. For example, some staff from CAMHS had needed to provide extra support to non-clinical colleagues in partner organisations when they received calls from young people in crisis, this had added to their own workload. Managers were aware of this and had worked with partner agencies to provide additional shadowing and training for frontline staff to up-skill them. All staff commented they enjoyed the new integrated model of working and that managers were proactive in addressing any unforeseen challenges.

Adherence to the Mental Health Act and the Mental Health Act Code of Practice

Staff understood their roles and responsibilities under the Mental Health Act 1983 and the associated code of practice. Staff had completed mandatory training that covered aspects of mental health law appropriate to their role. The trust had started to provide additional training on mental health law and how it interfaced with wider legislation relating to children and young people, but this had only recently started at the time of our inspection.

Staff had support on implementing the Mental Health Act and could access specialist advice from a mental health law service provided by a local mental health trust. Staff had access to relevant and up-to-date policies and procedures that reflected current legislation. Psychiatrists were able to gain further advice and opinions from other doctors when needed.

At the time of our inspection there were no young people using the service who were subject to a community treatment order. Care plans clearly identified young people subject to section 117 aftercare and detailed what services they needed.

Good practice in applying the Mental Capacity Act

Staff understood how to apply the Mental Capacity Act 2005 and when and assessed capacity when necessary. The Neurodevelopmental team had experience of working with young people whose complex needs may impact of their capacity to make decisions. Consent to treatment was recorded clearly in the care records we reviewed. Staff gave young people support to make specific decisions for themselves and assessed their capacity to make decisions where needed.

Staff received training on the Mental Capacity Act during their safeguarding training. Data supplied by the trust showed that in August 2019, 100% of CAMHS staff had completed Mental Capacity Act training at level one and 80% had completed more advanced training at level two. The trust stated that level one training was mandatory for all staff and level two was role-specific. Both levels of training were renewed every three years.

Staff understood how to support young people to make decisions about their own care and the principles of Gillick Competency. Families and carers who were used to making decisions for their children were, when needed, informed about how young people’s rights change as they get older.

This was particularly important for young people transitioning to adult services who may not have capacity to make their own decisions.

Is the service caring?

Kindness, privacy, dignity, respect, compassion and support

Young people, their families and carers received care and support from staff who were respectful and compassionate. Managers and staff went the extra mile to make sure their approach was friendly and inclusive. Young people and their families said staff were very approachable and helpful and we observed positive interactions between them. For example, during an assessment staff ensured the young person and their family took the lead on deciding the pace and structure of the session, ensuring their wellbeing was central to the whole process. Staff were considerate when arranging routine appointments and avoided times when young people had other commitments or added pressures, such as school exams.

Staff created a welcoming atmosphere and helped young people feel at ease wherever possible. In the waiting rooms there were toys available for younger children to use and bean bags were placed in clinics rooms as well as chairs. To make the environment more engaging, the service had worked with the Youth Board to commission a series of photographic self-portraits that reflected how the young people sitting for the photos said they felt about their own mental health. At reception staff greeted and communicated with young people in an appropriate manner that was not condescending. When external building works took place, staff had arranged for privacy screens to be put up on windows where scaffolding was in use to ensure young people's privacy was not compromised.

Staff clearly understood and respected the individual needs of each child or young person and gave them the help, emotional support and advice they needed. The service had responded to the cultural diversity of the local population and identified ways to deliver support that maintained young people's own individual beliefs. For example, the service linked into community support groups that offered individualised support for young people and families with specific cultural identities. Young people also told us that staff helped them access spiritual support if they wished.

Staff promoted other local support services and empowered young people to use them as part of their recovery and after their treatment had finished. The new integrated service model that had been co-designed with young people, allowed them easy access to other services in the local area to support their wider needs. This included access to social interventions and counselling services with third sector organisations, as well as signposting to digitally-based services that young people could access whenever they wished.

The culture of the service placed the wellbeing of young people and their families or carers as the leading priority. Staff felt that they could raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes towards young people and staff and were encouraged to speak up if they had concerns. Young people and families also told us they were able to raise concerns with the service openly.

Staff worked hard to protect the privacy and dignity of young people. Young people said staff treated them with dignity and did not patronise them. Staff followed policy to keep patient information confidential and only shared information if consent had been given.

Involvement in care

Involvement of patients

Young people were treated as partners in their own care and the staff we met were very committed to this. Staff worked alongside young people in the care planning process and supported them to make their own decisions about their care and treatment wherever possible. Care records we reviewed reflected this and showed that young people had been involved in assessing their own needs and staff had worked collaboratively to create individual recovery goals or strategies with them. Staff worked well with partner organisations to find ways to support younger people, who initially felt unable to engage, to grow in confidence and become more able to engage with the planning of their care and treatment.

Young people were empowered to shape the service and the way it was delivered so it met their needs. The service had worked with young people to ensure their voice was heard in the delivery of the service and we saw this was taken very seriously. Current and previous patients were able to join the service's Youth Board and get involved in the running of the service. Members were provided with multiple opportunities to influence the service and keep it relevant for young people. For example, members of the board were involved in the recruitment of senior members of staff and were invited to join the interview panel to ask questions. Prior to the launch of the new integrated model young people had been involved in the co-design of the service and had chosen the service's new name. Young people had also helped design a 'Wellbeing Suitcase' for mental health clinicians to use in schools to help facilitate student conversations about mental health. Members of CAMHS had been assigned to assist members of the Youth Board to realise their ideas and to provide emotional and organisational support.

Staff supported young people to understand and manage their care and treatment or condition and worked with them to explore different ways to communicate when needed. Information given to young people and families at every stage of their treatment used language that was appropriate and clear. At the start of their treatment each patient received a letter with a photo of their assigned clinician and an easy-read step by step explanation of what was going to happen next.

The Youth Board had also co-designed the service website, which gave a full explanation of the different teams, treatment routes and what support they could offer. It included helpful links for further information and a video about what to expect from the service.

Involvement of families and carers

The service valued the input and the individual stories of families and carers and used them to promote young people's recovery. Staff across all the teams supported families or carers to access a range of interventions to reinforce positive parenting skills. For example, the 'Growing Together' programme offered family psychotherapy, parenting workshops and group sessions in the community for parents to explore different ways to approach the challenges of parenting through personalised training. Where appropriate, interventions to address adult mental health issues, such as cognitive behavioural therapy, were also offered to parents. Parent and carer peer support groups had also been implemented in other areas of the service and were led by parent volunteers.

Parents said staff discussed options for treatment with the young person and themselves and felt they were listened to and respected by the service. They had also been provided with information on how to access a carer's assessment and further support in the community.

Staff were sensitive to the cultural beliefs and parenting styles of the individual families they worked with. This included delivering courses about dealing with anxiety in Turkish and Spanish and ensuring that group work with families did not make assumptions about family structure or roles.

Families told us they felt able to raise any concerns with the service openly and staff were proactive in responding to feedback they received. There were anonymous comment boxes in waiting rooms for people to leave their suggestions. The service also collected feedback using patient and family experience questionnaires. For example, the service had acted on recent feedback from patients about the environment at the Northern Health Centre and had purchased new chairs and updated the decoration of clinical rooms. The service displayed any response to feedback it had received on 'you said we did' posters in areas both young people and staff could access. Parents and carers were directed to other external user forum groups to take part in co-production activities across the local care pathway.

The service was enthusiastic about growing future opportunities to involve and support parents and carers further. At the time of our inspection the service was in the process of introducing a Parent Board to allow families and carers an opportunity to input into wider service decisions based on the success of the service's Youth Board.

Is the service responsive?

Access and waiting times

The service was accessible to the local community. Referrals were managed well to ensure people using the service received prompt care and a range of interventions according to individual and family needs. The new integrated Social Emotional Mental Health (SEMH) service had been designed with local stakeholders to incorporate a multiple-channel approach to access and referrals. Young people and their families could access support and self-refer at multiple settings, including schools, community centres and health centres. The referral and referral acceptance rate of the community CAMHS was very high when benchmarked with similar services nationally. The service had built strong working relationships with other local stakeholders, including fellow NHS providers and commissioners, to help influence decisions in the local care pathway.

The community child and adolescent mental health service (CAMHS) connected with other professionals including GPs, school nurses, health visitors and social services to ensure they sent referrals to the new central point of access within the SEMH service. However, the service had only been launched in September 2019 and some GP practices were still referring directly into the Community CAMHS team. The service was aware of this and teams were using ongoing engagement to address the problem and ensure all referrals were consistently directed to the new SEMH service.

The referral criteria for the service did not exclude young people who would have benefitted from care and support. Young people who did not meet the threshold for treatment for community CAMHS could still access alternative social and emotional support through partner organisations. For people who did require more specialist interventions, for example, those with possible autistic spectrum disorders, there were referral criteria in place. The new SEMH arrangements meant that any young person accepted on to a CAMHS team waiting list needed that service; those with less complex issues had their needs met by other SEMH teams.

The service did not meet the target time for seeing young people from referral to treatment set by commissioners but the waiting time to access services had improved since our last inspection. The

overall target time from referral to treatment for the service was eight weeks. Performance data that the trust shared with us, showed the average waiting time across the service had decreased continually from 28 weeks in June 2019 to just over 13 weeks at the end of October 2019. This was projected to further decrease to nine weeks by the start of January 2020 after the SEMH model had further embedded. The associate director of community CAMHS was working closely to monitor and address the issue at a strategic level with local partners and commissioners.

Despite this, young people who required urgent care were assessed and treated promptly. All urgent cases were seen by an adolescent assessment outreach team within an average of three days, meeting the national target. There was no waiting list for this team who offered interventions to those in crisis and a seven-day follow up to young people following a hospital mental health admission or treatment at an accident and emergency department.

Each team within community CAMHS monitored their wait times and some were meeting the target time. For example, the intake team and teams providing support to schools and families with children aged under five were able to offer treatment within eight weeks. Others, such as the neurodevelopmental team, had much longer waiting times due to the highly specialised, time intensive, nature of their work.

Team leaders used monthly data dashboards and explored new ways to improve waiting times. For example, the neurodevelopmental team had refined its information gathering process to reduce the length of time needed to conduct a full assessment and reduce waiting times without compromising service quality. The service had also worked with local commissioners to address the attention deficit hyperactivity disorder (ADHD) waiting list using locums and the waiting list had decreased as a result.

Where young people waited a long time, the service offered support and managed waiting lists effectively. For example, the intake team had expanded their tele-support offer to offer short-term interventions to young people who needed it quickly. Members of the intake team reviewed waiting lists daily and were assertive when coordinating care pathways with partner organisations to ensure no young people received support as quickly as possible. When appropriate, other teams offered group parenting sessions to families to help them support their own child whilst waiting for treatment from CAMHS clinicians.

Young people had some flexibility and choice in the appointment times available. The service endeavoured to meet young people and their families at times and places that were convenient. Some parents told us it was difficult to attend consecutive appointments that had to be delivered in a set timeframe, but the service would try and accommodate them. Staff worked hard to avoid cancelling appointments but if they did, they gave young people clear explanations and offered them new appointments.

Staff followed up with young people who missed appointments. For most CAMHS teams if the patient or their family did not attend the first two appointments or respond to any contact the patient would be discharged back to their GP or referrer. For young people with more complex needs or risks the service would conduct home visits and work with the local safeguarding team to ensure young people were protected in the community.

The structure of the SEMH service ensured that young people, who would benefit from care from another agency or internal team within community CAMHS or the wider SEMH service, made a smooth transition. A dedicated consultant psychiatrist was in place to work with young people, on a case by case basis, to manage the transition process to adult mental health services when needed and help make decisions during multi-agency reviews.

Facilities that promote comfort, dignity and privacy

The design, layout, and furnishings of treatment rooms supported young people's treatment, privacy and dignity. At the Northern Health Centre clinic rooms and rooms used for group work were adequately sound proofed and had screens on the glass door panels to uphold privacy. When external building works had been going on staff had arranged for privacy screens to be put up on windows where scaffolding was in use to make the environment as appealing and private as possible. A functional assessment room was available that allowed two-way observation through a mirrored screen. This was used to conduct specialist behavioural assessments. Where staff worked in rooms and offices maintained by other organisations they reported any issues with these premises to their manager to ensure action was taken.

When possible, staff endeavoured to meet young people in premises where they felt comfortable. This was particularly the case when staff were trying to engage with adolescents. At the Adolescent Outreach Team meeting they discussed going for a walk to a café with one young person to help build familiarity and trust.

Patients' engagement with the wider community

The service worked effectively with other local organisations and local initiatives to ensure young people were engaged with their community and had access to support networks. Community CAMHS collaborated with different organisations to connect young people to local resources to support their general health and wellbeing. This included supporting access to welfare support services, local volunteering initiatives, peer support groups and social clubs. To facilitate better conversations about mental health in the community the service's Youth Board had also designed a 'Wellbeing Suitcase' for clinicians to use in schools with students to explore issues around mental health using visual prompts.

Staff made sure young people could access information on treatment, other local services, their rights and how to complain. The Youth Board, formed from current and previous patients, had co-designed the community CAMHS website. The structure of the website made it easy to navigate and displayed information that was appropriate to the different age ranges of young people and their parents. Young people were able to find helpful links to local charities and support services, including child helplines, and information about how to complain or leave feedback about community CAMHS. At the time of our inspection, the service was working with other stakeholders in the SEMH model to further develop social prescribing and digital support options for young people and their families.

Meeting the needs of all people who use the service

The service strived to meet the needs of all people who used it, including those with protected characteristics. Adapting to the diverse needs of the local population was very much business as usual and staff were experienced in this. A lift was available at the Northern Health Centre and staff worked to ensure other locations used in the community were accessible to people with mobility needs. The Impact team within the service provided dedicated support to young people with complex disabilities and found creative ways of communicating with them. This had included developing easy-read materials with photos to explain to young people what their visit to CAMHS would be like in detail.

The service was responsive to the wider needs of the local population and diverse communities they worked in. Information was available to young people and their families in a variety of formats, so they could engage with people who had specific communication needs. Support was

provided for people who did not speak English as a first language. Information leaflets available in languages spoken by the young people and local community. Interpreters or signers were available when needed. Materials for parent groups were designed to be as inclusive as possible and staff had worked with young people with gender identity needs using an evidenced-based approach from a local specialist NHS service. Staff were careful not to make assumptions about family structure, so all close family members involved in supporting the young person felt welcome.

Listening to and learning from concerns and complaints

Young people, their families and carers knew how to complain or raise concerns. A patient advice and liaison service (PALS) worked across the trust and information about how to access their service was made available to people using the community CAMHS service. Young people and their families felt able to raise concerns openly with staff, without fear of discrimination or harassment. Most feedback we received about the service from young people and their families was positive.

Staff were pro-active in responding to feedback received. For example, the service had purchased new chairs and decorated appointment rooms from feedback received by young people stating the environment needed improving. The service displayed what action it had taken in response to feedback on ‘you said, we did’ posters. The service treated complaints seriously, investigated them and learned lessons from the results, sharing these with the whole team and wider service. Staff understood the trust’s policy on complaints and knew how to handle them. This service received two formal complaints between August 2018 and July 2019 that were partially upheld. In both instances senior managers had investigated the complaints and provided feedback to young people and their families or carers. Staff across the service were aware of these complaints and associated learning had been shared with them.

The service used compliments to learn, celebrate success and improve the quality of care. This service received one formal compliment during the last 12 months from August 2018 to July 2019. The team sent out regular service user experience questionnaires and had over 120 respondents within the last year. We found many of these responses were very positive about the service with people agreeing that the service had ‘listened to them’, ‘treated them well’ and confirming they had ‘received good help’. The service had also received positive feedback from the trust’s family and friends test.

Is the service well-led?

Leadership

Leaders had the skills, knowledge and experience to perform their roles and demonstrated a strong understanding of the services they managed. An associate director and clinical lead provided local leadership for the community child and adolescent mental health services (CAMHS) and had been in post for less than 12 months at the time of our inspection. Despite this they had already created positive change to the way the service was delivered. For example, the new working arrangements of the Social Emotional Mental Health (SEMH) model were being quickly embedded and any associated issues addressed promptly.

Leaders within the service and those from the wider trust were visible in the service. Individual team leaders were skilled in supporting and directing their team and there was excellent communication and team working demonstrated by all staff across the service. All staff commended the leadership provided by their managers and felt supported and trusted. Members

of the senior leadership team for the wider trust had visited the service, including the director of operations who attended the last quality and performance meeting with team leaders. Staff also received information and updates from the trust's chief executive officer through a monthly newsletter and online blog.

Staff were supported to develop their skills and take on more senior roles. Managers across the team had accessed the trust's 'iCARE' values-based leadership development programme to develop their skills. Team leaders said they felt empowered to take more control of their team's individual performance in relation to achieving the wider service strategy. Following a consultation, team leaders' pay grades were aligned to recognise their equal contributions towards the effectiveness of the service. All staff received annual appraisals and regular supervision to help identify opportunities for further development.

Senior managers and team leaders demonstrated clear understanding of the issues, priorities and challenges the service faced and worked collaboratively with other organisations to address them. For example, the service recognised the need for further out of hours support for young people who presented in crisis situations at emergency departments. Senior managers were working closely with other providers across north central London to help plan the future implement of a nurse-led CAMHS out of hours crisis service.

Vision and strategy

The vision of the service was aligned with plans for the wider health economy and showed a strong commitment to local collaboration. Leaders in community CAMHS had embedded a system-wide approach to the planning and delivery of the new SEMH service to create positive impact in the community. Staff showed a unified approach in achieving a service where young people and their families were put first, and local services worked together to create a truly holistic care pathway. For example, the service had received local recognition from the criminal justice system for the expertise they provided at pupil referral units, helping prevent younger people becoming involved in criminal activity such as knife crime.

There was an integrated approach to monitoring, reviewing and providing evidence of progress against the service's strategy and plans. Managers monitored the progress of the service against the wider local strategy using measurable outcomes and data dashboards. These outcomes were used to support strategic objectives and inform discussions with local commissioners to plan for the sustainability of the service.

Managers from community CAMHS communicated well with other organisations within the local care pathway. A regular meeting between all services within the SEMH service took place and the representatives we spoke with said that, as a group, they were proactive in identifying the wider needs of the community. Team leaders were also supported to engage with and attend meetings in the local community that were relevant to their specialist workstream for example school forums. Partner organisations said they were impressed with how well community CAMHS had worked collaboratively with them to achieve shared goals.

Managers paid close attention to the skill mix of their teams to ensure it reflected the current and future needs of the local population. The service had a recruitment strategy in place to ensure the right staff were available to meet the current and emerging needs of the local population. For example, there were plans in place to further expand the expertise within CAMHS by recruiting a nurse prescriber to better provide medicines support.

Culture

Despite the service have only been reconfigured and introduced a new service model very recently there was strong collaborative culture between all teams.

Staff were passionate about their work and motivated to succeed. All staff showed enthusiasm and passion when working with external teams to meet the needs of young people and their families. Young people, parents and partner organisations said staff were committed to the people who used their service and put their needs at the centre of service delivery.

Staff felt respected, supported and valued. Staff were proud of the service as a place to work and spoke highly of the culture senior managers had helped to create. Teams understood one another's challenges and worked cohesively to share learning and identify areas for improvement. The service had introduced annual awaydays to bring all staff across the large service together. Staff said this had been a great achievement and made them feel more unified as a team.

Resources were available to staff to support their wellbeing. This included access to occupational health services and staff-led initiatives such as yoga groups. Staff wellbeing was discussed at all team meetings and supervisions and staff said managers were considerate. Some teams had incorporated mindfulness techniques during group supervision to aid staff wellbeing.

Staff showed commitment and took effective action towards ensuring equality and inclusion across the workforce. When interviewing for more senior clinical roles a member of staff from a minority ethnic group had to be present on the interview panel. The service had also supported staff with additional needs such as physical disabilities and adapted the workplace to meet their needs. Equality and diversity training were mandatory for all employees and managers encouraged staff to access further training such as 'unconscious bias'.

Staff could raise concerns without fear of discrimination or victimisation and policies and procedures were in place to support this. Speak up inclusion champions were in place across the trust to offer advice and visited community CAMHS regularly. During 2018 the trust had commissioned an independent review of workplace culture across the entire hospital and had acted on the findings. Managers had attended training including 'caring for those that care' and bullying awareness to help implement a healthy organisational culture. The annual response rate to the staff survey had increased in the CAMHS team from 35% to 65%, although analysis of the recent results had not been finalised at the time of our inspection.

When needed, managers dealt with poor performance with individual members of staff and handled the situation professionally. The associate director could access expert support from a central team in the trust to manage performance issues and used a performance dashboard to monitor any emerging issues across the different teams within the service.

Governance

Leaders had embedded systems and processes to ensure the performance of the service was communicated to all relevant stakeholders. Any issues or achievements within the service were reported effectively from floor to board. The trust had relevant oversight of community CAMHS via a quality and safety group and the board's quality committee.

As well as being accountable through internal mechanisms to the trust board, the service had clear lines of accountability to commissioners and external partner organisations. The outcomes of many aspects of each team's work were reported, usually bi-monthly, to commissioners.

Community CAMHS staff at all levels were clear about their roles and managers showed a deep understanding of their own team's performance and the impact it had on the wider service. Teams used clinical audits and outcome monitoring to ensure effective care was delivered that was safe and responsive to the needs of young people. The associate director had worked with managers to incorporate the use of data dashboards and key performance indicators to share best practice and identify areas for improvements across all community CAMHS teams. However, further work was needed to ensure all team managers were using the recently revised data dashboards to full effect. Some managers were still not confident in using aspects of the data management system and could not readily access the most recent version of their team's data dashboard.

Despite this, we found that managers were fully aware of any issues within their teams and had plans in place to address them. This included the waiting times for some services that exceeded the target set by commissioners. Managers were also working with staff to address the initial challenges they faced in relation to record keeping when working between multiple electronic systems within the new SEMH model.

Management of risk, issues and performance

Leaders managed performance using systems to identify, understand and monitor risks at the appropriate level. The associate director reviewed all risks across the service and worked with a central team within the acute trust to maintain a risk register and ensure the trust's board had relevant oversight of risks. For example, the service had recently taken steps to minimise the risks relating to the security of information when teams worked out in the community. Staff equipment had been updated so they were able to store notes electronically whilst out in the community rather than taking notes on paper.

Staff were effective at working collaboratively with each other and other stakeholders to address risks and performance issues. The service used systems to monitor waiting lists for individual teams and other services within the integrated SEMH model and to identify areas for improvements. The service had worked with local commissioners to address the attention deficit hyperactivity disorder (ADHD) waiting list using locums and the waiting list had decreased as a result.

Managers received helpful data regularly to identify problems, hold them to account and improve performance where possible. Staff completed quality audits and used data dashboards detailing key performance indicators to measure the performance. Senior managers had good oversight of performance issues within their teams and across the wider service and put plans in place to address them. The associate director used benchmarking to manage performance against other services on a national level. Work was ongoing to standardise data collection across all teams wherever possible and the service benefitted from having an allocated data manager available to provide them with support.

Service developments and changes were developed and assessed with input from clinicians so that they did not impact negatively on the quality of care delivered. For example, the associate director was working with commissioners to streamline contract monitoring arrangements to minimise the time spent on data collection and maximise the time spent on clinical work.

Information management

Staff had the information they needed to deliver care and support and it was stored securely on the trust's electronic patient record system. Staff were able to access the information they needed with ease, but it was noted that some adjustments to the record keeping system were still needed

to make it more efficient. For example, risk assessments and risk management plans were recorded in the daily progress notes using a naming convention, so they were easy to find. This worked well on a day-to-day level but did not lend itself to central reporting as statistical data could not be extrapolated.

Integrated reporting and management of information was used between organisations and teams to support effective decision making. Other children's services within the trust, for example health visitors and paediatricians, stored their information on the same electronic record keeping system as the community CAMHS teams. This meant that key information regarding young people, such as risk assessments and wider health needs, could be shared between different teams with ease. The teams were also efficient in collecting and storing information from other agencies involved in care pathways, including referrals from GPs and social service teams.

Leaders across the community CAMHS teams understood the importance of data to effectively manage and deliver high quality services. They were proactive in recognising and acting on concerns relating to data management systems. Following a recent meeting the performance dashboards had been redeveloped to reflect and align with the new SEMH structure.

The information used for performance management was mostly valid, reliable and timely. The associate director was experienced in using data in a systemic way to improve quality. They were working with a data manager to improve the accuracy of information used. For example, when young people had been offered an earlier appointment the data system recorded this as a cancellation, despite the person getting earlier than expected access to the service.

Engagement

The service was proficient at engaging with young people, staff, the public and local organisations to help improve services and treated them as partners in care. The new SEMH service had been designed in collaboration with a range of local stakeholders. The model had been a direct result of listening to the local population who said they needed greater access, choice and reduced waiting times for children and young people who required support for their emotional wellbeing and mental health.

Ideas from, and participation of, people who used the service and other stakeholders were welcomed and seen as a vital way of improving services. A Youth Board, formed from current patients and previous service users, influenced decisions about the way the service was delivered and highlighted issues using the personal experience of its members. The service also provided opportunities for families and carers to input into service development by encouraging people to join service user forums in partner organisations, ensuring their voice was heard across the local system and not community CAMHS alone.

The service used community engagement methods to build capability within the community to support young people and families with mental health problems. This included raising awareness of Adverse Childhood Experiences (ACEs) with local stakeholders to help support the most vulnerable children and young people in the local area. Teams supporting children under five had used evidenced-based training programmes to up-skill local nursery staff and parents as a preventative approach to tacking mental health issues in young children.

Learning, continuous improvement and innovation

Staff demonstrated a proactive approach to embedding new, more sustainable, models of care and engaged in improvement work locally and nationally. For example, as part of NHS England's National Trailblazer programme the service was launching Mental Health Support Teams (MHSTs) in local schools, colleges and pupil referral units across the borough. The new service would build

capacity within school settings by training educational professionals to provide early intervention for mild to moderate mental health and emotional wellbeing issues. Clinicians within the community CAMHS team would provide supervision and support to the MHSTs. The MHSTs will also work closely with the SEMH model to further broaden the range of interventions available to young people in the local community and make them even more accessible. This new service was expected to go live in 2020.

Staff were supported to lead and deliver change. Community CAMHS participated in trust-wide quality improvement audits and carried out their own internal audits within teams. Staff were encouraged to implement pilot projects to test and improve ways of working. For example, a new way of delivering interventions for young people with emotional and behavioural disorders had been shown to be effective. The Neurodevelopmental team had also completed a programme of work to refine the patient assessment process and reduce the length time people waited, without compromising the integrity or quality of the specialist service. This had enabled them to reduce the waiting time for the service and save an estimated 100 hours of clinical time each month. This learning had been shared across other teams in community CAMHS who were now looking to embed a similar approach.

Leaders took a whole system approach to providing learning opportunities and improving services across the local area. The service delivered training and shared expertise with other organisations in the community to build resilience and support for young people and families with mental health problems. Staff had raised awareness of implementing trauma-informed approached with stakeholders, such as staff at local nurseries and schools, to support the most vulnerable children and young people in the borough. Staff had helped organise conferences and learning events with other organisations on specific topics, such as supporting children with eating disorders and a were due to run a trauma conference in February.

The service supported a Youth Board which helped them to keep in touch with what was important to young people. They used their skills and knowledge to good effect at all levels of the service, from interviewing senior staff to developing resources to take into schools and to redesign the community CAMHS web pages.

All teams shared a strong focus on continuous learning and improvement. The large size and diverse pool of expertise within the teams led to excellent opportunities to learn from colleagues and cross-fertilise new ideas. Members of the different teams were very willing to share their skills and experience and had regular opportunities to do so at team meetings and awaydays. However, one staff member pointed out that there was a need for extra resources to organise the infrastructure changes needed to embed new ways of working and learning. This issue had been recognised by the associate director and a dedicated quality improvement lead was expected to be in place across the division within the next year.