Barts Health NHS Trust

Whipps Cross University Hospital

Quality Report

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

Ratings

Overall rating for this hospital	Requires improvement
Surgery	**Inadequate**
End of life care	**Requires improvement**
Outpatients and diagnostic imaging	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

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

Whipps Cross University Hospital provides a range of general inpatient services with 586 beds, outpatient and day-case services, as well as maternity services and a 24-hour emergency department and urgent care centre. The hospital has various specialist services, including urology, ENT, audiology, cardiology, colorectal surgery, cancer care and acute stroke care.

This was a focused unannounced inspection to follow up on our previous inspection of Barts Health NHS Trust in July 2016 where we found a number of concerns around patient safety and the quality of care. At that time Whipps Cross University Hospital was rated overall inadequate.

We carried out an unannounced inspection between 10 and 11 May 2017 and inspected three core services: surgery, end of life care and outpatients and diagnostic imaging.

We found improvements in both end of life care and outpatients and diagnostic imaging, which have been reflected in the ratings. However, following concerns we found in surgery the ratings across each domain remain unchanged. We have written to the trust asking them to provide further information on how they are addressing the issues of poor care and treatment.

However, when considering the aggregated ratings across all eight core services, from both this inspection and last July, the hospital is now rated overall requires improvement.

Our key findings were as follows:

Safe

- The hospital's electronic incident reporting system was not always used effectively by staff to report, investigate and act upon incidents. Learning from incidents was not always identified or recorded. Feedback was not shared consistently with staff, as monthly ward meetings did not always take place.
- VTE screening compliance on surgical wards was consistently below the trust's 95% target.
- Surgical site infection (SSI) data was not followed up and therefore the service did not know how many wound infections occurred after patients were discharged.
- We observed a number of infection control issues related to the operating theatre environment including loose and exposed plaster on theatre walls and damaged flooring. Not all theatre areas had records of daily cleaning checks and some items of equipment labelled as clean had visible dust and/or damage. We did not see evidence of any theatre cleaning audits.
- Not all staff had completed mandatory training.
- The use of agency staff on some wards was high due to nursing staff vacancies. Nursing staff told us they were concerned about the quality of the agency nurses and gave us examples when this compromised patients' care and treatment.
- We found there was a lack of working equipment available within the mortuary.
- Palliative care staffing levels fell below nationally recommended standards.
- The environment of the in-patient diagnostic imaging area was poorly maintained.
- Safety equipment was not always maintained or replaced to ensure the safety of patients or staff.

Effective

- We did not see evidence of how national audit results were being used to drive local improvement programmes. The trust did not provide us with any action plans to demonstrate how national audit results were responded to.

Summary of findings

- Not all patients were screened for malnutrition as required by NICE guidelines. MUST compliance rates for surgical wards were still consistently below the trust target of 95%.
- Patient outcomes were not being measured for patients receiving end of life or palliative care.

Caring

- Most patients we spoke with told us their experiences of care were positive. We saw that staff treated patients with compassion and demonstrated a genuinely kind and caring attitude.

Responsive

- Theatre cancellations were happening on the day of surgery due to lack of available beds and over-running and late starting theatre lists. Theatre utilisation rates had improved but were still below the trust's target. Theatre lists were frequently delayed due to IT and equipment issues and last-minute list changes.
- Bed shortages on wards meant recovery areas were regularly used to nurse patients overnight. Staff were concerned that patients' needs were not being appropriately met.
- Many patients were discharged out of hours (after 8pm) due to delays. The hospital did not carry out discharge audits and did not monitor their performance against the 48hr rapid discharge target for patients receiving end of life care.
- Provisions for relatives who were at the hospital with their loved ones for long periods of time were not consistent and differed from ward to ward.
- The availability of single rooms was at a premium in the hospital, which made dignified care for people at the end of their lives harder.
- There were capacity issues in certain clinics and some clinics were cancelled due to lack of clinician availability.

Well-led

- We saw limited evidence of improvements to the surgical service to make it safer for patients and more responsive to their needs. Many of the areas of concern highlighted during our last inspection still needed to be addressed by the service.
- Governance systems were not always embedded in practice to provide a robust and systematic approach to improving the quality of services.
- The risk register did not reflect all current risks to the service. Some risks had been on the register for several years and it was not clear when these had last been reviewed. The risk register did not show what controls were in place or actions taken to mitigate risks.
- Staff we spoke with were not aware of a nominated non-executive director for end of life care, or of any representation at board level. There was a culture for end of life care in the hospital to be seen as the responsibility of the specialist palliative care team.
- There was limited oversight of the extent or depth of potential patient harm as a result of a recent information technology systems failure.

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

Importantly, the trust must:

- The trust must ensure governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services. This should capture relevant elements of good governance including an adopting a positive incident reporting culture where learning from incidents is shared with staff and embedded to improve safe care and treatment of patients.
- The trust must improve bed management, theatre management and discharge arrangements to facilitate a more effective flow of patients across the hospital and to improve theatre cancellation and delayed discharge rates.
- The trust must improve its referral to treatment time performance in line with national standards.
- The trust must improve staff compliance with mandatory training including safeguarding training.

Summary of findings

- The trust must improve staff compliance and awareness of trust infection prevention and control policies and processes.
- The trust must improve compliance with venous thromboembolism (VTE) assessments.
- The trust must ensure all patients are screened for malnutrition as required by NICE guidelines.
- The trust must ensure that patient records are stored securely in line with information governance standards.
- The trust must ensure the hospital's physical environment, including operating theatres, is fit for purpose and meets required standards.
- The trust must continue to work towards improving the organisational culture to reduce instances of unprofessional behaviours and bullying and ensure all staff feel sufficiently supported by their managers.
- The trust must ensure there are sufficient numbers of qualified, skilled and experienced staff employed and deployed to meet the needs of patients. This should include ensuring staff have the right skills to recognise and manage the deteriorating patient.
- The trust must ensure all staff receive appropriate support, training, professional development, supervision and appraisal as is necessary to enable them to carry out the duties they are employed to perform.
- The trust must ensure that risks to patient safety and service delivery are appropriately identified, recorded and escalated effectively.
- The trust must ensure governance systems are embedded in practice to provide a robust and systematic approach to improving the quality of services.
- The trust must ensure compliance with radiation protection regulations.
- The trust must ensure that timely arrangements are in place to replace diagnostic imaging equipment identified as at risk of failure.
- The trust must ensure there are functioning panic alarms across the outpatients department.
- The trust must ensure that the environment is safe where children and young people are treated in adult clinics.
- The trust must ensure that equipment used for moving deceased patients from the ward to the mortuary are properly maintained and suitable for the purpose for which they are being used.
- The trust must ensure that systems and processes are in place to enable proper management and oversight of the mortuary and are understood by staff who provide mortuary duties out of hours and in the absence of regular staff from the outsourced third party.
- The trust must have systems in place to assess and monitor their performance for rapid discharge and its effect on patient care.
- The trust must assess the quality of services provided (including the quality of the experience of service users in receiving those services) in relation to its current palliative care consultant resource and with consideration to meeting the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)] which recommends a minimum requirement of 1 whole time equivalent consultant in palliative medicine per 250 hospital beds. The hospital has 586 beds.
- The trust must ensure that ward staff are provided with appropriate support and training in end of life and palliative care to enable them to carry out their role effectively.

In addition the trust should:

- The trust should ensure staff always have access to reliable equipment to minimise potential delay to treatment.
- The trust should ensure that timely arrangements are in place to replace ageing theatre equipment identified as at risk of failure.
- The trust should ensure the needs and preferences of patients and their relatives are central to the planning and delivery of care at the hospital.
- The trust should review, and take action to address, feedback from staff raised in the NHS staff survey.
- The trust should act upon the results of national audits to address areas of poor performance and to help drive improvement in services.
- The trust should ensure that surgical site infection (SSI) data is appropriately captured and reviewed.

Summary of findings

- The trust should ensure the safety of patients as they are transferred between CT and accident and emergency.
- The trust should ensure training is provided for the role of chaperone.
- The trust should ensure the physical environment is fit for purpose and maintained in a good state of repair.
- The trust should ensure the business continuity plan is updated to reflect systems failures in outpatients and diagnostic imaging services.
- The trust should ensure privacy for patients who attend the CT scanning unit.
- The trust should ensure best practice around the use of appropriate interpreters.
- The trust should ensure a consistent approach to sending reminders to patients about their appointments.
- The mortuary audit from March 2017 reported on the age and number of the fridges available and recommended it for entry onto the trust risk register. The trust should ensure this issue is given proper consideration.
- The trust should ensure that the second mortuary viewing room (in the accident and emergency department) is in a good state of repair.
- The trust should ensure that the new clinical records system that contains mechanisms for patient outcome data to be collected is utilised. The outcome measures had been on the new system since March 2017. The SPCT had used it for a matter of weeks and were not yet in use.
- The trust should ensure that work taking place to increase the limited multidisciplinary input in to the Margaret Centre and SPCT such as social work, therapy and psychological services, is continued.
- The trust should ensure that it conducts a review regarding the inconsistency of provision available for relatives who were at the hospital with their loved ones for long periods of time. For instance, in relation to items such as tea and coffee, and for relatives staying overnight.
- The trust should ensure that religious texts are readily available to patients of all major faiths who use the hospital.
- The trust should ensure that information gathered from both 'Have Your Say' and the bereavement survey are used to improve care.

Professor Edward Baker
Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Surgery	Inadequate 	We saw limited evidence of improvements to the service to make it safer for patients and more responsive to their needs. Many of the areas of concern highlighted during our last inspection still needed to be addressed by the service. We were told that significant work had now been done to improve the hospital's clinical governance structures; however, we did not see evidence that this had been embedded in surgical specialities. The risk register did not reflect all current risks to the service. Some risks had been on the register for several years and it was not clear when these had last been reviewed. The risk register did not show what controls were in place or actions taken to mitigate risks. The hospital's electronic incident reporting system was not always used effectively by staff to report, investigate and act upon incidents. Learning from incidents was not always identified or recorded. Feedback was not shared consistently with staff, as monthly ward meetings did not always take place. VTE screening compliance on surgical wards was still consistently below the trust's 95% target. Data provided by the trust for the period April 2016 to May 2017 showed overall monthly VTE screening rates on surgical wards varied between 75% and 86%. Three wards, Rowan, Sage and Sycamore scored consistently under 70%. Not all staff had completed mandatory training. Overall compliance rates fell below the trust target. Competition rates for medical gas safety and infection prevention and control (IPC) were particularly low at 75% against the trust's 90% target. Not all staff received an annual appraisal, appraisal rates were varied between 56% and 77% for different groups of surgical staff. The use of agency staff on some wards was high due to nursing staff vacancies. Nursing staff told us they were concerned about the quality of the agency nurses and gave us examples when this compromised patients' care and treatment.

Summary of findings

Theatre cancellations were happening on the day of surgery due to lack of available beds and over-running theatre lists. Theatre utilisation rates had improved but were still below the trust's target. Theatre lists were frequently delayed due to IT and equipment issues and last-minute list changes. Data provided by the trust for the period November 2016 to April 2017 showed that 79% of lists did not start on time, with 39% of lists starting over 30 minutes later than planned.

During our previous inspection, we identified that poor collaboration, communication and lack of understanding between different clinical areas within the service resulted in staff blaming each other for poor patient flow. Staff told us that this was still a problem and we saw little evidence of improvement.

Bed shortages on wards meant recovery areas were regularly used to nurse patients overnight. Staff were concerned that patients' needs were not being appropriately met.

A number of staff in different areas told us about ongoing issues of bullying, favouritism or unfair treatment. Several staff told us they lacked confidence in the hospital's HR department and felt reluctant to raise concerns.

In the NHS staff survey 2016, the staff response rate for the surgical and cancer division was 29.4%, which was significantly worse than the overall trust response rate of 47.3%. The service performed significantly worse than the trust average in questions related to staff engagement with senior manager

Not all patients were screened for malnutrition as required by NICE guidelines. MUST compliance rates for surgical wards were still consistently below the trust target of 95%.

The hospital's performance in the 2016 Hip Fracture Audit was mixed. For five measures, the hospital performed significantly worse than the national average and fell within the lowest 25% of all trusts. Performance against four of these five measures was also worse than the result for 2015. The trust did not provide us with any action plans to demonstrate how these national audit results were being responded to.

Summary of findings

The overall 18-week referral to treatment time (RTT) performance for patients waiting for surgical specialties at the hospital was 69%. Performance was worse than expected but could not be accurately measured against the national average due to quality issues. There were significant data quality concerns that meant the trust could not provide assurance that referral to treatment times were being monitored effectively and the trust were not submitting national data.
We also found:
We saw that staff treated patients with compassion and demonstrated a genuinely kind and caring attitude. Most patients we spoke with told us their experiences of care were positive.
Morning and evening handover at shift change were relevant and focused on patient care and safety.
Staff we spoke with knew how to report an incident and were aware of their responsibilities to report safeguarding concerns.
A nursing representative from each hospital area attended a daily safety huddle to enhance patient safety across the hospital.
Patients' pain was assessed and well-managed and ward staff had access to support from a specialist pain team.
Daily multidisciplinary team (MDT) board rounds took place on wards with input from range of allied health professionals.
Staff across wards and theatres spoke highly of their direct line managers and said they felt supported by the matrons who were visible and approachable
Most staff spoke highly of their team and colleagues.
A junior member of staff said they felt their colleagues were "like an extended family."
The trust had held several 'listening into action' events to capture the views of staff.

End of life care **Requires improvement**

Although ward staff felt well supported by the specialist palliative care team (SPCT) it was a widely held belief among senior staff at the Margaret Centre and SPCT that a barrier to promoting a positive culture of end of life and palliative care being everyone's responsibility and lay with the education of ward staff.
Despite issues regarding equipment being identified through audit and reported as acted on in March

Summary of findings

2017, we found there was a lack of working equipment available within the mortuary. Twenty fridge spaces were available in the mortuary and deceased patients were frequently transferred to other premises. There were no bariatric fridge spaces and the audit stated that fridges were quite old. It recommended this issue for the trust risk register. Out of hours mortuary viewings were arranged and managed by the porters. However, the porters had not been trained in any mortuary duties.
More clinical nurse specialists and consultants had been recruited as part of investing in end of life and palliative care which was a positive step. However, not all posts had been recruited to and staffing levels remained on the risk register. Consultant levels had increased and were due to increase further. However, they were still below the national guidance ['Commissioning Guidance for Specialist Palliative Care: Helping to deliver commissioning objectives' (Dec 2012.)] which recommends a minimum requirement of one whole time equivalent consultant in palliative medicine per 250 hospital beds. Association for Palliative Medicine of Great Britain and Ireland recommendations and the National Council for Palliative Care guidelines of a minimum of one consultant per 250 beds. The hospital had 586 beds.
Provisions for relatives who were at the hospital with their loved ones for long periods of time were not consistent and differed from ward to ward. Some were provided with tea and coffee, others with tea, coffee and sandwiches. For relatives staying overnight, some wards could only provide chairs while others had fold down beds.
The availability of single rooms was at a premium in the hospital, which made dignified care for people at the end of their lives harder; this compounded the issue of patients being sent to the Margaret Centre, where care was provided in single rooms.
The discharge team told us they tried to meet a target of 48 hours for rapid discharge. However, although they monitored this on a day to day basis they did not measure this in any other way, such as over time or through any sort of audit and did not understand their effectiveness against this target or its effect on patient care.

Summary of findings

Staff from both the SPCT and Margaret Centre we spoke with were not aware of a nominated non-executive director for end of life care, or of any representation at board level.
There was a culture for end of life care at the hospital to be seen as the responsibility of the SPCT. There was also a culture of patients being admitted to the Margaret Centre to die rather than being cared for at home or on the wards.
The mortuary was managed by an outsourced third party on behalf of the trust. There were systems in place that were not effective and others that the trust had no oversight of.
We also found:
There were mechanisms in place for learning from incidents to take place through a multi professional, cross divisional hospital group who led on all matters that related to end of life and palliative care.
The SPCT took working to resolve issues for patients receiving end of life care as something they took responsibility for within the hospital. They described being open, apologetic to people when things went wrong and resolving matters for patients.
Ward staff, the SPCT and staff at the MC were all able to describe the trust's safeguarding referral process. They also knew when it was appropriate to seek help and advice as well as escalate potential safeguarding issues. We came across one current example of this in practice.
A programme of refurbishment was taking place at the Margaret Centre. Updates had already taken place to the premises to improve infection control and protect peoples' privacy and dignity.
The compassionate care plan for the dying patient (CCP) was in use throughout the hospital. Staff we spoke with on hospital wards and at the Margaret Centre told us that the end of life care was hugely helped by having the CCP in place.
Patient deterioration, symptom management, continuing assessment and ongoing monitoring for each patient where appropriately discussed and reviewed in daily handover meetings at both the SPCT and MC.
We found plenty of examples where end of life care was being delivered to national guidelines and in compliance with National Institute for Health and Care Excellence (NICE).

Summary of findings

			DNACPR forms were in place and fully completed, including discussions with the family where appropriate. There was only one DNACPR form in use now. The Margaret Centre and the SPCT staff worked on relationships with services within the hospital to promote better end of life care. Ward staff we spoke with thought both the SPCT and the MC staff were helpful. Patients and relatives were positive about the care they had received. Family meetings were held soon after referral to the SPCT. Family involvement was discussed in handover meetings of the SPCT and the Margaret Centre. There was a good meeting structure that enabled accountability and direction for end of life care. The deteriorating patient improvement group met on a monthly basis and was the principle governance meeting for the hospital that was concerned with end of life care. This group was now developing in to the end of life care group, which was to be led by the director of nursing at the hospital.
Outpatients and diagnostic imaging	**Requires improvement**		Incidents were not always reported or actioned in line with trust policy. The trust had identified capability issues with staff using the incident reporting system, however we were told this training was not included in induction training. Risk registers did not reflect all areas of concern, for example; concerns about transfers of patients between the emergency department and imaging department or lack of accessible resuscitation equipment The environment of the in-patient diagnostic imaging area was poorly maintained. There were on-going capacity issues in certain clinics to meet patient demand Staff did not have the available information to ensure non-medical referrers were compliant with the Ionising Radiation (Medical Exposure) regulations (IR (ME) R). Safety equipment was not always maintained or replaced to ensure the safety of patients or staff. In particular lead aprons, which provided radiation protection.

Summary of findings

Radiation doses received by medical staff was routinely higher than that recommended by the radiation protection advisor when measured against staff who performed similar procedures using x-ray equipment with modern dose limiting technology for the patients and operators.
There was limited oversight of the extent or depth of potential patient harm as a result of a recent information technology systems failure.
Governance systems were not always embedded in practice to provide a robust and systematic approach to improving the quality of services.
Staff told us management was more visible.
There was an improved staff culture, some of which staff attributed to a greater willingness amongst managers and the human resources department to tackle bullying issues.
We also found:
Most patients were positive about the care they received and were treated with dignity and respect.
Guidelines such as those published by National Institute for Health and Care Excellence (NICE) were in place and followed.
Booking centre staff consulted with patients to ensure the appointment slot was convenient for them and accommodated their needs.
Staff spoke positively of the newly appointed leadership team, and described an improved culture and better communication between staff and managers.
Most patients and relatives we spoke with were positive about how they had been treated and we observed consistently good interactions.
Staff had appropriate safeguarding awareness and understood their safeguarding responsibilities in and protected people from abuse.
Medicines were generally stored safely and there was robust management of medicines administration records and prescription stationery.
There were improved radiography staffing levels as a result of a recent recruitment campaign.
Systems were in place to maximise patient record availability for clinics which meant staff had the information they needed before providing care and treatment.