London North West University Healthcare NHS Trust

Northwick Park Hospital

Inspection report

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Ratings

Overall rating for this service	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive to people's needs?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Overall summary of services at Northwick Park Hospital

Requires Improvement 

London North West University Healthcare NHS Trust is one of the largest integrated care trusts in the country, bringing together hospitals and community services across Brent, Ealing and Harrow. London North West University Healthcare NHS Trust operates hospital services from three main hospital sites:

• Northwick Park Hospital

• Ealing Hospital

• Central Middlesex hospital.

The trust employs more than 9,000 clinical and support staff and serves a diverse population of approximately one million people. The trust also provides a range of community services in the London Boroughs of Brent, Ealing and Harrow. The trust was last inspected in 2019 and was rated requires improvement overall.

The trust provides, urgent and emergency care, medical care, surgery, critical care, maternity, gynaecology, children and young people services, end of life care and outpatient services. The trust also provides a range of community services including: diabetic eye screening, district nursing, falls services, family dental, musculoskeletal specialist and physiotherapy services and many more. We inspected two core services at Northwick Park Hospital.

Our inspection was unannounced to enable us to observe routine activity. Before the inspection we reviewed information we had about the trust based on the intelligence we had received.

We carried out an unannounced focused inspection of the emergency department at Northwick Park Hospital on 19 and 20 April 2021, in response to concerning information we had received in relation to the care of patients in this department. We also took into account nationally available performance data and concerns we had received about the safety and quality of the services. At the time of our inspection, the department was under adverse pressure due to the COVID-19 pandemic.

We carried out an unannounced focused inspection of the maternity service on 19 and 20 April 2021 at Northwick Park Hospital in response to concerns we had received in relation to the care of mothers and babies in the department.

Focused inspections can result in an updated rating for any key questions that were inspected if we inspect the key question in full across the service and/or we had identified a breach of a regulation, and issued a requirement notice or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

Following this inspection, under Section 31 of the Health and Social Care Act 2008, we sent the trust a letter of intent to take urgent actions as we believed people would or may be exposed of risk to harm.

Maternity services:

Our findings

We rated this service as inadequate at this inspection. Overall, we rated safe, and well-led as inadequate. The ratings in effective, caring and responsive stayed the same. In maternity we found:

- Mandatory training compliance was not in line with the trust target of 85%. Medical staffing compliance was poor and not on the service's risk register.
- We were not assured the trust had effective systems in place to ensure that medical and midwifery staff had the competence, skills and experience to safely care for and meet the needs of women and babies within all areas of the maternity service.
- Staff did not always complete and update risk assessments for each patient and did not always remove or minimise risks. We found domestic violence was not always documented.
- We found that the triage function was not using Maternity Early Obstetrics Warning Systems (MEOWS) scoring in the records we reviewed and was relying on clinical judgement to escalate patients. The triage area had not been audited since 2018 and we were not assured women were seen in a timely way.
- The service did not always manage patient safety incidents well. We were not assured incidents were always reported in a timely way and that lessons learned were always shared amongst the whole team and the wider service. When things went wrong, there were concerns that there was a lack of transparency through fear of being blamed.
- We were not assured the leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety. The governance structure and leadership team were new and had not embedded practice to implement change at the time of the inspection. Leaders said it was still very early in the process.
- We found policies that were not up to date to ensure staff deliver high quality care according to evidence-based practice and national guidance.
- We found doctors, nurses and other healthcare professionals did not always work together as a team to benefit women. We were not assured they supported each other to provide good care.
- The service did not have a good culture and there were multiple allegations of bullying. There were mixed views regarding whether staff felt respected, valued and supported.
- We were not assured staff were always focused on the needs of the women receiving care, and whether the service promoted equality and diversity in daily work.
- We were not assured all leaders were aware of the challenges to the service. Some leaders did not know what was on the service's risk register and there were long standing issues which had not been addressed. Some staff said leaders were not visible and did not act in a timely way to address issues within the service.
- We were not assured risk management was robust and identified all risks within the service.
- Staff understood how to protect women from abuse however safeguarding training compliance was not always meeting the trust target and domestic violence assessments were not documented in all women's notes.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Medicines were stored securely in all the clinical areas we visited.

Our findings

- Following the external reviews of the maternity services, the trust had developed a Maternity Improvement Plan based on recommendations from external reviews which incorporated suggestions from the engagement work that was ongoing with staff.

Urgent and emergency services:

We did not rate this service at this inspection. The previous overall rating of requires improvement remains. In urgent and emergency services we found:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service generally controlled infection risk well. Staff wore the right personal protective (PPE) to keep themselves and others safe from cross infection. Patients had an assessment of their infection risk on arrival at the department and staff allocated them to the correct areas.
- 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. The service had enough medical staff to ensure safe care was provided at all times
- Staff mostly kept detailed records of patients' care and treatment. Records were clear, up to date and stored securely.
- 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.
- Patients could access the service when they needed and were able to access treatment promptly. The trust had significantly improved their patient handover and treatment time performance.
- 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.
- 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.
- Leaders and teams used systems to manage performance effectively. They identified and escalated most relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

However:

- Senior leaders were not aware of all of the risks in the department. We were told that staff were responsible for changing the filters on masks and the leadership team did not monitor this or have oversight of this. Therefore, we were not assured the filters were changed in a timely manner as per guidelines which could create a risk for both patients and staff.
- Patient safety checklists were not consistently filled in for three sets of records that we reviewed.
- Nursing staffing vacancies remained a challenge for the department. The service acknowledged that there were vacancies particularly for band five nursing staff. The department leaders had been working on recruitment in order to improve this vacancy rate. Managers regularly reviewed and adjusted staffing levels and skill mix, and regular bank and agency staff were used to fill gaps.

Professor Edward Baker Chief Inspector of Hospitals

How we carried out the inspection

Our findings

We visited the emergency department at Northwick Park Hospital on 19 April 2021. We visited all areas of the emergency department including the paediatric emergency department. We conducted interviews with staff members on 19 April 2021 and 20 April 2021.

We reviewed 23 patient care records and observed the care provided. We spoke with 24 staff members including nurses, matrons, practice development nurses, junior doctors, middle grade doctors, coordinators, consultants, healthcare assistants, senior leaders, administrative staff and one patient.

We also reviewed the trust's performance data and looked at trust policies for the emergency department.

We visited maternity services at Northwick Park Hospital on 19 April 2021. During the inspection we visited the labour ward, postnatal and antenatal areas, admission triage area, day assessment unit and theatres. We conducted interviews with staff members on 19 April 2021 and 20 April 2021. We spoke to 39 staff including service leads, matrons, midwives, medical staff and maternity care support workers.

We also reviewed the trust's performance data and looked at trust policies for the maternity service.

You can find further information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Maternity

Inadequate 

The maternity services at Northwick Park Hospital comprises of an acute site with community midwifery services in various locations.

The maternity services at Northwick Park consist of an obstetric-led delivery suite (labour ward), a midwife led birth centre and Florence Obstetrics ward. There is also a fetal medicine unit, day assessment unit, maternity theatres and recovery.

The trust has 69 maternity beds which is made up of a 19 bedded delivery suite, 31 beds on Florence obstetric ward and 19 beds on the midwife led birth centre.

The consultant-led delivery suite is located on the ground floor and has two dedicated obstetrics theatres and a recovery bay for post-operative women.

Between April 2020 and April 2021 the maternity services had the following activity:

- Total number of births: 4116
- Total C section rate = 1560 (37.9%)
- Elective section rates = 610 (14.8%).
- Emergency section rates = 950 (23.1%).
- A total of 501 (12.2%) of the activity entails instrumental deliveries and this is within the LMS Green Flag range of ≤ 16%
- Total normal vaginal delivery = 2054 (49.9%)
- Total instrumental delivery = 501 (12.2%)
- Total non-interventional vaginal delivery = 1553 (37.7%)
- The midwives Whole Time Equivalent (WTE) for the last financial year was 157.74 WTE
- The Consultants Whole Time Equivalent for the last financial year was 21.2 WTE substantive consultants and four WTE locum consultants
- The ratio of births to midwifery staff in the last financial year was 1:28
- The ratio of senior midwives to midwives in the last financial year was 1:14

We inspected Northwick Park Hospital maternity services in June 2018 as part of a comprehensive trust inspection. We had found maternity services were inadequate overall and carried out a focused inspection in January 2019 to see if the service's performance had been maintained or if any improvements had been made. At the July 2019 comprehensive inspection the provider rating improved from inadequate to requires improvement. However, there were still some concerns identified. These included the service not controlling infection risk well, obstetricians not attending evening handover, staff reported staff shortage and systemic issues around culture.

We carried out an unannounced focused inspection of the maternity service on 19 and 20 April 2021 at Northwick Park Hospital in response to concerns we had received in relation to the care of mothers and babies in the department.

Maternity

Prior to this inspection, we became concerned about a cluster of perinatal deaths and whistle-blower concerns regarding cultural issues and the lack of presence of senior management within the maternity department at Northwick Park Hospital.

Focused inspections can result in an updated rating for any key questions that were inspected if we inspect the key question in full across the service and/or we had identified a breach of a regulation, and issued a requirement notice or taken action under our enforcement powers. In these cases, the ratings will be limited to requires improvement or inadequate.

We rated this service as inadequate at this inspection. We rated safe, and well-led as inadequate. We did not have sufficient evidence to rate effective and responsive. We did not inspect caring.

We found the following concerns:

- Mandatory training compliance was not in line with the trust target of 85%. Medical staffing compliance was poor and not on the service's risk register.
- We were not assured the trust had effective systems in place to ensure that medical and midwifery staff had the competence, skills and experience to safely care for and meet the needs of women and babies within all areas of the maternity service.
- Staff did not always complete and update risk assessments for each patient and did not always remove or minimise risks. We found domestic violence was not always documented.
- We found that the triage function was not using Maternity Early Obstetrics Warning Systems (MEOWS) scoring in the records we reviewed and was relying on clinical judgement to escalate patients. The triage area had not been audited since 2018 and we were not assured women were seen in a timely way.
- The service did not always manage patient safety incidents well. We were not assured incidents were always reported in a timely way and that lessons learned were always shared amongst the whole team and the wider service. When things went wrong, there were concerns that there was a lack of transparency through fear of being blamed.
- We were not assured the leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective at implementing meaningful changes that improved safety. The governance structure and leadership team were new and had not embedded practice to implement change at the time of the inspection. Leaders said it was still very early in the process.
- We found policies that were not up to date to ensure staff deliver high quality care according to evidence-based practice and national guidance.
- We found doctors, nurses and other healthcare professionals did not always work together as a team to benefit women. We were not assured they supported each other to provide good care.
- The service did not have a good culture and there were multiple allegations of bullying. There were mixed views regarding whether staff felt respected, valued and supported.
- We were not assured staff were always focused on the needs of the women receiving care, and whether the service promoted equality and diversity in daily work.
- We were not assured all leaders were aware of the challenges to the service. Some leaders did not know what was on the service's risk register and there were long standing issues which had not been addressed. Some staff said leaders were not visible and did not act in a timely way to address issues within the service.

Maternity

- We were not assured risk management was robust and identified all risks within the service.
- Staff understood how to protect women from abuse however safeguarding training compliance was not always meeting the trust target and domestic violence assessments were not documented in all women's notes.

However:

- The service controlled infection risk well. Staff used equipment and control measures to protect women, themselves and others from infection. They kept equipment and the premises visibly clean.
- The service used systems and processes to safely prescribe, administer, record and store medicines. Medicines were stored securely in all the clinical areas we visited.
- Following the external reviews of the maternity services, the trust had developed a Maternity Improvement Plan based on recommendations from external reviews which incorporated suggestions from the engagement work that was ongoing with staff.

Is the service safe?

Inadequate 

Our rating of safe went down. We rated it as inadequate.

Mandatory training

The service provided mandatory training in key skills however not all staff had completed it. Managers did not monitor mandatory training; this was done by the education team.

- The service's mandatory training was monitored by the education team which consisted of one lead educator and four practice educators. This team covered the service seven days a week.
- The education team told us training completion was monitored electronically and staff received reminders when training was due. If staff did not attend (DNA) training they were rebooked onto the next date. Any further non-attendance was escalated to the matron. Both matrons we spoke with could not tell us the mandatory training compliance for their areas so we were not assured they had oversight.
- Mandatory training was reviewed each year by the education team to ensure key training needs were included in mandatory training. This was reviewed by the consultant midwife.
- The trust target for mandatory training was 85% and data provided by the trust showed this was not met for multiple training modules. The trust said COVID-19 had impacted the ability for staff to attend mandatory training. We were informed training was paused in December 2020 due to the pandemic and had significantly impacted the ability to conduct face to face training due to social distancing and risk. The trust said the target for compliance for the maternity services was August 2021. However, this was not on the service's risk register.
- For nursing and midwifery staffing, compliance was below the trust target for Fire Safety (67%), Infection Control (78%), Manual Handling Level 2 (84%), Basic Life Support (BLS) (73%), Safeguarding Adults Level 2 (54%).

Maternity

- For medical staff, compliance was below the trust target for Fire Safety (52%), Health and Safety (84%), Infection Control (67%), Information Governance (67%), Manual Handling Level 1 (74%), Manual Handling Level 2 (76%), PREVENT (71%), BLS (45%), Safeguarding Adults Level 2 (54%), Safeguarding Children Level 1 (82%) and Safeguarding Children Level 3 (53%).
- In addition to the trust's mandatory training, maternity staff attended Practical Obstetric Multi-Professional Training (PROMPT) style 'skills and drills' training. This had moved to virtual training due to COVID-19.
- The service had systems and processes in place to assess and monitor staff competency in relation to cardiotocography (CTGs). Staff were required to attend annual training on performing, reading and interpreting CTG outputs for women and were assessed for competency on completion. Staff were required to attend the PROMPT training before the CTG training which was run three times a month. The pass mark is 90% for band 7 midwives and 85% for band 5 and 6 midwives. At the time of our inspection, compliance for midwives was 97.4%. However, compliance for junior doctors and consultants was poor at 64% and 37% respectively.

Safeguarding

Staff understood how to protect women from abuse. However, we were not assured all risks were appropriately identified and escalated. Mandatory training compliance for safeguarding did not meet the trust target for some modules and domestic violence was not always assessed.

- Midwifery and medical staff were required to attend training specific to their role around how to recognise and report abuse. For nursing and midwifery staff, Safeguarding Adults Level 2 (54%) was below the trust target at (85%). For medical staff, Safeguarding Adults Level 2 (54%), Safeguarding Children Level 1 (82%) and Safeguarding Level 3 (53%) and PREVENT (71%) were all below the trust target of 85%.
- Staff knew how to identify adults and children at risk of, or suffering, significant harm such as physical or sexual abuse and worked with other agencies to protect them. Staff knew how to make safeguarding referrals and who to inform if they had concerns.
- The service had added a new risk to the risk register in March 2021 regarding women not being assessed for domestic violence at every antenatal appointment. When we reviewed records only two out of 10 had been assessed for domestic violence. Therefore, we were not assured safeguarding was always thoroughly assessed and escalated.
- Following the inspection, we asked the trust to provide urgent assurance that domestic violence was assessed at all antenatal appointments. The provider submitted results from two audits. One audit had looked at booking forms for December 2020 and found compliance was 93%. However, this audit only considered whether it was assessed at the time of booking and not at all other antenatal appointments. The provider had then conducted an audit of eight patient paper records in April 2021 and found domestic violence was recorded in seven out of eight cases. The service said they would audit this again in May 2021 and planned to conduct spot checks in the two weeks following our inspection.
- There was a named lead midwife for safeguarding who provided support, supervision and updates to staff.
- There was a two-step process to making safeguarding referrals. Safeguarding concerns were reported to the incident reporting system and escalated to the safeguarding team. The staff were then also required to make additional referrals to other teams such as the vulnerable women team, mental health team and local authority. When concerns were reported on the system, the safeguarding team would check staff had made all the correct referrals. Any safeguarding referrals were then triaged through a weekly psychosocial meeting which were held jointly with other agencies.
- Safeguarding policies and clinical pathways were up to date and accessible to staff via the trust's intranet.

- There was a named midwife for Female Genital Mutilation (FGM) and a weekly FGM clinic for women. There was a FGM policy available on the trust intranet and at the time of the inspection the policy was being reviewed via the trust's ratification process. The trust's safeguarding policy explained child sexual exploitation CSE and how to report it. Staff had knowledge of CSE and knew how to escalate concerns.
- There was a baby abduction policy in place and the wards undertook baby abduction drills. The education team said staff demonstrated they could appropriately follow the baby abduction policy during the training drill.

Cleanliness, infection control and hygiene

The service controlled infection risk well.

- Cleaning records were up to date at the time of the inspection, and records provided demonstrated that all areas were audited for cleanliness. On Florence ward, compliance between April 2020 and March 2021 was between 96% and 98%. On labour ward compliance between March 2020 and February 2021 was between 98% and 100%.
- We reviewed hand hygiene audits on Florence ward between April 2020 and March 2021 and compliance varied between 89% and 100%. On labour ward compliance between March 2020 and February 2021 varied between 95% and 100%.
- Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. 'I am clean' stickers were visible on all freestanding equipment, doors etc. Furnishings were clean and well-maintained.
- There was a staff member situated at the main entrance to the maternity department who conducted temperature checks, ensured people entering used hand gel and provided masks.
- The majority of staff followed the infection control principles including the use of personal protective equipment (PPE). Staff had good access to PPE, and all staff were wearing appropriate PPE at the time of the inspection. All staff were bare below the elbows and observed hand hygiene procedures. We observed adequate supplies of hand gel and sinks available.
- However, we did find some examples of poor practice. We observed that during the ward round on labour ward staff did not wash or gel their hands before entering patients' rooms or between patients. We also observed some examples of staff members moving through the wards with their face masks pulled down below their mouths.
- In the 2019 CQC Maternity Services Survey, the trust scored worse for the question relating to cleanliness of hospital room or ward.
- MRSA screening on labour ward between March 2020 and February 2021 was 100%.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe however checks of emergency equipment were not now always completed. Staff managed clinical waste well.

- The service had a refurbishment over the months before our inspection. This included all the patient facilities in Outpatients and a refurbishment of Florence Ward and the Delivery Suite which included new lighting and bathroom facilities.
- The service had also updated the staff facilities. There was a new command room in the labour ward for MDT working and a new simulation suite for teaching in the unit which was not in use at the time of the inspection. However, the senior leadership told us this would be up and running soon. However, we were not told the exact date for this.

Maternity

- The service had suitable premises and equipment to care for women and babies and keep them safe. Treatment rooms and clinic rooms were uncluttered and organised and accessible.
- Equipment we checked throughout the inspection had up to date safety testing, including resuscitaires, defibrillators and blood pressure machines.
- The matron on labour ward identified two of the labour rooms' stirrups had been escalated as requiring maintenance. These had all been checked following an incident.
- We reviewed the adult resuscitation equipment on Florence ward and reviewed the daily check records between January 2021 and April 2021 and identified one missed check. We saw that neonatal resuscitaires required checks to be completed twice a day by staff. We reviewed records between December 2020 and April 2021 and found the sheets were missing for February 2021 and March 2021. We also found that for some days the resuscitaires had not been checked twice. Following the inspection, the trust submitted the missing sheets which showed checks for these months had been completed. We viewed the service's quality board which said there had been no missed checks of adult resuscitation equipment between April 2020 and March 2021 despite us identifying a missed check.
- There were checks in place for the post-partum haemorrhage (PPH) trolley on Florence ward to ensure it was fully stocked.
- We reviewed the resuscitation equipment and PPH trolley in the birth centre and found no missed checks. The neonatal resuscitaire had two missed night-time checks in March 2021.
- We reviewed the resuscitation equipment on labour ward and checks were completed in most instances. However, the Major Obstetric Haemorrhage (MOH) trolley had multiple missed checks between February 2021 and April 2021. This could put patients at risk if equipment was missing and/or out of date.
- There was also a protocol available for staff which informed them of the modification to resuscitation for women who may have COVID-19. This shared information about safe practice for PPE.
- There were two theatres in use in the maternity service. Both theatres were available 24 hours a day, seven days a week. We were told if a third theatre was required, patients would be taken to the main theatre areas in the hospital.
- The trust were monitoring the incidence of puerperal sepsis and other puerperal infections within 42 days of delivery and readmission rates for infections in mothers and babies. This was part of the maternity dashboard. Between April 2020 and March 2021 the trust were rated 'green' for all months except April, June and July 2020 in which they were rated 'amber'.

Assessing and responding to patient risk

Staff did not always complete and update risk assessments for each patient and did not always remove or minimise risks.

- The maternity service had a triage area but did not have dedicated medical staff allocated to the area. We were told triage was covered by the labour ward clinicians which meant they could be busy covering labour ward especially at times of high acuity. Staff were using a specific proforma for triaging women however Modified Early Obstetrics Warning Scores (MEOWS) were not part of the assessment. There was no audit in place to assess whether women were seen in a timely way in triage. We reviewed three patient records in triage and none of them had the Modified Early Obstetrics Warning Scores (MEOWS) completed for women.

Maternity

- Triage staff were not rag (risk) rating women who attended and there was a lack of MEOWS scoring on the three records we checked. There was no audit in triage to assess if women were seen within 30 minutes. Patients were triaged based on clinical judgement and not by a specific criteria. We reviewed the triage book and saw the time was not recorded consistently for when women were seen on dates between 9 and 19 April.
- Following the inspection, we requested audit data for triage services and were informed noaudits had taken place since 2018. The trust said no audit had taken place in 2020 due to COVID-19, however we were not informed why an audit had not taken place in 2019. Therefore, there was a lack of oversight of the triage services and we were not assured women were being seen and escalated in a timely way to keep them safe.
- Following the inspection, we asked the trust to urgently provide assurance that women were triaged in a timely way to keep them safe. The trust conducted an audit on 23 April 2020 of 31 records. The audit showed 90% of women were seen within 30 minutes and 88% had the front sheet triage tool completed appropriately**.** However, the trust recognised they did not routinely use MEOWS in triage. The trust immediately actioned this and told us they will be introducing a new triage tool with MEOWS assessments. This will be audited in May 2021 to assess compliance. The provider also added this to the service's risk register following the inspection.
- During the inspection concerns were raised regarding delays in the induction of labour for women and an allegation that women were often waiting longer than 72 hours to be induced. Following our inspection, we requested further information from the trust regarding induction rates and length of time women were waiting to be induced.
- Following the inspection, we asked the trust to urgently provide assurance that women would induced in a timely way. The trust conducted an audit on 23 April 2021 of 21 patient records. The audit found that in half of the cases women were induced within 48 hours. However, there were delays for the other half of the patients. The service stated 'this is largely attributed to the capacity in both our antenatal and labour ward areas at peak time'. The trust also sent an action plan and added this to the risk register.
- We reviewed the Induction of Labour Policy and found there was disparity between the recommendations in this and recommendations in the Vaginal Birth after C-Section guideline. We were told by staff that women with reduced fetal movement were offered an induction of labour at 37 weeks. However, when we reviewed the policy this was not detailed in the guideline.
- We reviewed the shoulder dystocia guideline which was in date. However, there was no information around debrief of women and counselling for future pregnancies.
- The Integrated Care System (ICS) external review into eight perinatal deaths identified concerns with how the maternity services were conducting risk assessments and escalating mothers appropriately where risks were identified.
- A safety recommendation from a Health and Safety Investigation Branch (HSIB) report stated the trust should align the risk assessment tool used for fetal growth at booking. They also recommended the trust should align its referral pathway of growth scans with the Saving Babies Lives V2 (2019). As part of the trust's improvement plan following the ICS external review the trust were in the process of implementing the Saving Babies Lives (SBL) care bundle (v2). The trust aim was to have this embedded by June 2021 and this involved a training programme and plan for an audit for compliance.
- The maternity service had co-produced a fetal movement video with the Maternity Voices Partnership (MVP) which was available in different languages. The service had also employed a fetal monitoring midwife and had named leads which was shared with staff.

Maternity

- The external review also recommended the trust risk assessment in antenatal care must include: blood pressure and urine analysis, mothers' sensation of fetal movement, accurate Symphysis Fundal Height (SFH) measurement after 26 weeks, review of ultrasound scans, the assessment and reassessment of appropriate place of birth and after 28 weeks advise of action for reduced fetal movement. The trust's improvement plan indicated that the completion date for this was July 2021. Therefore, at the time of the inspection this was not being audited.
- The Saving Babies' Lives (SBL) care bundle was produced to help reduce perinatal mortality across England. The care bundle brings together five elements of care that are recognised as best practice. The maternity service was not compliant with uterine artery doppler and pre-term clinics. COVID-19 had impacted the roll out of the doppler service but the plan was for this to commence in June 2021. A locum had been appointed to undertake the pre-term clinic who was due to start in April 2021.
- In the 2019 CQC Maternity Services Survey, the trust scored worse for the question related to the women being left alone by midwives or doctors at a time when it worried them.
- There were signs throughout the department regarding the 24-hour maternity helpline which had been introduced for women. We were told this helpline was run by midwives who were currently shielding. Women could access this helpline if they required any advice or support.
- National Early Warning Scores (NEWS) snapshot audit results were displayed on Florence ward quality board and performance between April 2020 and March 2021 was between 93% and 100%.
- Staff completed Venous Thromboembolism (VTE) assessments in line with service guidelines. VTE is a life-threatening condition where blood clots forms in a vein. Of the 10 records we viewed VTE assessments were completed in all 10 records. Audit data for post-natal ward showed compliance for VTE from April 2020 and March 2021 was between 95% and 100%. Audit data for labour ward between March 2020 and May 2020 was 100%. However, data from May 2020 to date had not been displayed on the quality board.
- We saw no evidence in the 10 records we reviewed that women had received Carbon Monoxide (CO) monitoring. A briefing guide set out by Public Health England for midwifery staff states that, "smoking in pregnancy poses significant health risks to the mother and to baby". We asked why CO monitoring was not being conducted and was told that due to the COVID-19 pandemic, the trust was following national recommendations at the time of the inspection and had paused CO testing of pregnant women.
- The service was not consistently auditing swabs and instruments following vaginal births. The department had conducted a retrospective audit of 15 patients and identified that only two patients (13%) had their count accurately recorded. As a result the service reviewed the proforma and told us they will be changing it so it is easier for staff to use.
- We reviewed the Sepsis Policy and found this was out of date as it was due for review in August 2020. The trust informed us this was out of date due to COVID-19 and was due for review at the next clinical guidelines group in May 2021. The policy had no clear plan for escalation for midwifery staff. There was an algorithm but this did not define MEOWS where escalation was necessary. We were provided with an audit of the sepsis policy which identified the sepsis six pathway was used in only 69% of cases. The trust were actioning this and had plans to re-audit the sepsis pathway. Following the inspection, we received an updated Sepsis Policy which was ratified in April 2021. We reviewed this document which showed that the MEOWS trigger was part of the sepsis escalation policy.
- The World Health Organisation (WHO) five steps to safer surgery checklists were in use in obstetrics theatres. This included a safety briefing, sign in, time out and sign out. The service audited this on a monthly basis and compliance between April 2020 and March 2021 was between 96% and 100%.

- The morning briefing in theatres for elective caesareans included discussions that included but not limited to patients' placental site, consent, notes reviewed/available, neonatal concerns, isolation for three days, COVID-19, MRSA, bloods. It also included a briefing of equipment available, equipment issues, capacity, staffing and beds, potential emergencies on labour ward. There was also a debrief of the time the list finished, things that went well, any problems or issues, lessons learned and areas for improvement.

Nursing and Midwifery staffing

The service did not have enough maternity staff with the right qualifications, skills, training and experience to keep women safe from avoidable harm and to provide the right care and treatment.

- Between April 2020 and March 2021 the vacancy rate for Florence ward varied between 8% and 28% with the highest rate in June 2020. The sickness rate for the same dates varied between 2.7% and 16.5%. The registered midwife day fill rate varied between 85% and 107% and the night shift rate between 90% and 104% for the same dates.
- Between March 2020 and February 2021 the vacancy rate for labour ward varied between 15.6% and 28%. The sickness rate for March 2020 was 13.3%. We asked the deputy head of midwifery about the sickness rate for February 2021 but they did not know what the actual figure was so we were not assured they were checking data. Following the inspection we were told that the sickness rate in February 2021 was 5.6%.
- Following the inspection, we requested a breakdown of staffing vacancy rates for the maternity services. The vacancy rate for band 6 midwives was 35.2% and band 7 was 7.8%. However, the band 5 establishment was over established at 127% and this was due to the high band 6 vacancy rate.
- The total number of midwives was 181.4 WTE and the number of maternity support workers was 20.6 WTE. This was a ratio of one maternity support worker to 8.8 midwives. This did not meet the Birth Rate Plus recommendations of one maternity support worker to six midwives. Therefore, the service was an outlier for the Birth Rate Plus staffing model.
- Following the inspection, we requested the service's bank and agency usage. There were high rates of agency usage between September 2020 and February 2021 with the average being 20.4%. The trust said a reason for the high rate were staff vacancies and COVID-19 and staff shielding. However, the trust said a high number of agency staff were staff who have been working with the trust regularly.
- The service leads said that they were aware staffing levels were an ongoing issue within the service. The deputy head of midwifery said the service was trying to grow their own band 6 midwifes via the preceptorship programme. However, staff would often leave for other roles within the inner London pay banding.
- We spoke to the executive leadership team regarding the staffing issues within maternity services. We were told a workforce plan for maternity had gone to the quality committee. Part of the trust's plan was to ensure a more robust exit interview process and to use feedback from this to feed into the maternity improvement plan. The trust said they were discussing the potential of overseas recruitment and were discussing recruitment with Capital Nurse International Recruitment Consortium.
- The Day Assessment Unit (DAU) was open seven days a week from 8am to 8.30pm. DAU is an outpatient service that assesses mothers and babies during pregnancy. The DAU was staffed by two midwives and one maternity assistant. On the day of the inspection, we visited DAU and there was only one midwife working as the second midwife shift was not filled. The maternity assistant had also been taken from labour ward. The DAU was not cleared and there were patients waiting. Staff told us staffing issues were a regular problem.
- We reviewed the maternity safer staffing and escalation guideline. This was up to date and was due for review in October 2022. The guideline contained detail of how to flag staffing issues and guidelines for escalation. However, there was no information regarding use of an acuity tool and therefore complexity of care did not seem to be taken

into account. Multiple staff told us the patient group at Northwick Park was complex and the lack of an acuity tool could put women at risk if staffing levels were not reflecting the acuity of patients. When we asked senior leaders regarding use of an acuity tool we were informed they had recently received a report from Birth Rate Plus. Following the inspection, we requested this information. When the trust sent it to us, it did not contain any trust explanation around their analysis of the report and what changes they were going to make as a result of the report.

- Most staff we spoke to raised concerns about the staffing levels and high use of agency staff. Junior staff raised concerns about being asked to act up into band 7 coordinator roles without wanting to do this. We raised this with senior leaders who were aware that this happened. Coordinator roles on the labour ward and birth centre were supernumerary and were not included as part of the planned numbers for the shift. The ICS external review had made a recommendation that newly qualified staff should always be supported by experienced midwives on every shift. We were not assured that this was happening.
- Staff told us they often had to miss their lunch breaks due to staffing levels. One staff member said they had given up escalating this as it was such a common occurrence. We reviewed NRLS data and saw there were multiple incidents over the last 12 months where staff are reported not getting their breaks. Having overtired staff is a risk to patient safety.
- The trust reported 13 patient safety incidents as a result of staffing numbers between April 2020 and March 2021.
- There was a senior midwives on call rota which we reviewed for April 2021 and this had no gaps.
- Ward Matrons received annual electronic confirmation that agency midwives' skills were compliant with the Capital Midwifery skills passport. The trust said the matrons were accountable for ensuring all agency staff are up to date with their training which incorporates obstetric emergencies, CTG and basic life support. However, when we asked the matrons about levels of compliance with mandatory training they were unable to tell us. They told us that this was the role of the education team. Therefore, we were not assured there was good oversight of staff training by the ward matrons.

Medical staffing

The service had enough medical staff with the right qualifications, skills, and experience to keep women and babies safe from avoidable harm and to provide the right care and treatment.

- The service had enough medical staff to keep women and babies safe. There were 4116 births between April 2020 and March 2021 with 24 obstetricians in post. The ratio of consultant to births was 171.5. The national recommendation is 1 to 278 births (Maternity Workforce Strategy March 2019).
- There were 10 available theatre sessions with gynaecology which had reduced from 20 due to COVID-19. For obstetrics, there were five elective caesarean lists per week which were available 24 hours a day.
- The Senior House Officer (SHO) rota had 21 posts with no vacancies. The SHOs were available 24 hours a day 7 days a week.
- The Registrar rota had 18 registrars in post with no vacancies. There was a senior registrar available on call overnight who covered labour ward. We were told all situations were handled by the senior registrar. Consultants were called in if there were any issues with patient care. We were told consultants tend to be at home overnight but will be available over the phone. However, some staff said consultants were reluctant to come and see patients when requested.

- There was mixed feedback regarding consultants attending the ward. One staff member raised concerns that consultants do not attend the ward when there are breeches and twins and that there was no trigger list in place for them attending labour ward at night. However, another said they did attend. A third staff member said when they escalated patients to the consultant they often had to chase this multiple times to get them to attend the birth centre.
- On labour ward consultant presence was from 8am to 8pm seven days a week. We were told a different consultant was then available overnight on call.
- Labour ward had recently recruited a locum doctor into the post of clinical lead for the ward. When we asked the senior leadership why a locum was the current lead clinician for labour ward we were told this was the best person for that post currently.
- In the 2019 General Medical Council (GMC) National Trainee Survey scores were significantly below the national aggregate for four questions. These were around teamwork, handover, educational supervision and feedback. Scores were below the national aggregate for induction.

Records

Staff kept records of women's care and treatment but these were not always fully completed. However, records were stored securely, and most were available to staff providing care.

- Staff kept records of women's care and treatment. The maternity service used a combination or paper-based and electronic records. In total we reviewed 14 patient records, 10 records on Florence ward, three records in triage and one record on labour ward. Maternity records were stored securely within the maternity unit.
- Risk assessments were completed in 10 paper records we reviewed on Florence ward. Completion was good for the majority of items. However, we found the domestic abuse question had not been asked in any of the records. When we asked staff about this they informed us this was recorded on the electronic records. When we checked the electronic records we found this to be incorrect. We saw that they asked three questions, namely: a question about mental health, whether the patient was accompanied and whether the women had time alone with the staff. This was only completed for two visits in all the records we reviewed.
- We observed that the application of the 'fresh eyes' approach where a second staff member checked records, was embedded in practice. All records had 'fresh eyes' documented.
- We found one risk assessment was completed incorrectly. Within the risk factors section the staff member had said there were no risk factors and that the women had not recently arrived in London from another country. However, within the written notes it was documented the women was a late booking and had recently arrived from Romania. Therefore, we were not assured this risk assessment was completed accurately.
- Maternity Early Obstetric Warning Scoring system (MEOWS) were in use in the department. For the 10 paper records we reviewed we found MEOWS was completed for all 10 records. However, the three records we reviewed in triage and the one record from labour ward did not have MEOWS scores completed.
- Labour ward displayed the results of National Early Warning Scores (NEWS) between March 2020 and February 2021 and compliance was 100%
- We reviewed women's records to see if staff had offered Vitamin D appropriately with an explanation to women with darker skin. We found no evidence in all 10 records that this had been offered. Guidance for women is that they

should take a 10 microgram (or 400 IU) supplement of Vitamin D each day. This is highly recommended for autumn and winter months. Following the inspection, we were told that women did have their Vitamin D levels checked during the booking process with the antenatal clinic and that this was recorded within the maternity electronic record system rather than on handheld records.

- Discharge summaries were sent to health visitors and GPs. The summary included information about the women's pregnancy, labour and postnatal care, any medications they had been prescribed, and any ongoing risks.
- The senior leadership team told us the trust had plans to implement a new electronic system. However, we did not find out when this was due to be implemented.
- We reviewed National Reporting and Learning System (NRLS) and found that between April 2020 and March 2021, 73 incidents had been recorded relating to documentation (including electronic and paper records, identification and drug charts).

Medicines

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

- The service used systems and processes to safely prescribe, administer, record and store medicines. Medicines were stored securely in all the clinical areas we visited.
- Maternity wards used an automated dispensing system which provided safe storage and dispensing of medicines. The system required fingerprints from two staff members to dispense medicine. Stock checking was automatic,
- Controlled drugs (CDs) were stored in the electronic system and staff were required to scan into this where CDs such as epidural were required. Access required two staff members present. We reviewed the controlled drugs book for epidural and found this was appropriately completed and accurately recorded what was available in the dispenser.
- Medicines management audits were completed on Florence ward and results were displayed on the quality board. Compliance between April 2020 and March 2021 were between 95% and 100%. On labour ward compliance between March 2020 and February 2021 was 100%.
- We reviewed 10 prescription charts and found they were legible, named, dated, allergies and weight were clearly documented, and administration and route of administration were also clearly recorded.
- We reviewed records for temperature checks for fridges storing medication. All checks were completed and temperatures were within the expected ranges.

Incidents

The service did not always manage patient safety incidents well. There were delays in the investigations of incidents and lessons learned were not always shared amongst the whole team and the wider service. When things went wrong, there was concerns that there was a lack of transparency.

- There were zero never events recorded within obstetrics in the 12 months prior to our inspection. 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 had happened for an incident to be a never event.

Maternity

- Prior to inspection, we had been informed of two maternal deaths (death of a mother) within the last 12 months, which had been reported via the National Reporting and Learning System (NRLS) system and investigated as serious incidents. NHS Improvement (2017) Learning from Deaths states “Maternal deaths and many perinatal deaths are very likely to meet the definition of a Serious Incident and should be investigated accordingly”.
- We reviewed serious incident (SI) process for maternity services. There were 13 serious incidents reported by the trust between March 2020 and March 2021. Serious incidents were events in health care where there was potential for learning, or the consequences were so significant that they warranted using additional resources to mount a comprehensive response. We reviewed some serious incident reports and found this identified potential learning for services.
- There were eight perinatal deaths reported over a five-week period between July 2020 and August 2020. Health and Safety Investigation Branch (HSIB) reviews were in progress for some of the cases but as there were eight cases over a short period of time the trust escalated this to the North West London Integrated Care System for an External Review. This review highlighted a number of concerns and 28 recommendations were made to the maternity services. Areas for improvement related to performing of risk assessments, access to interpreting services, identification of small babies, escalating women with multiple attendances to urgent care, consultant involvement in complex cases, Multidisciplinary Team working (MDT), support for midwife staff, MDT training and fetal and neonatal monitoring.
- The trust had an improvement plan in place to address the issues identified form the ICS external report.
- We reviewed NRLS and found between April 2020 and March 2021 there were 1310 incidents reported for obstetrics and gynaecology of which three were reported as severe harm, 22 deaths, 92 moderate harm, 252 low harm and 926 no harm.
- We reviewed the Incident Reporting and Investigation Policy. This was last reviewed in April 2019. Staff are required to report incidents to their line manager and complete report on the incident reporting system. This is then sent to a Senior Manager who reviews the grading of the incident.
- Senior leaders told us staff received feedback from investigation of incidents, both internal and external to the service. There was a ‘Risk Newsletter’ which shared learning from serious incidents. We saw the risk newsletter displayed on Edith ward which contained information about the learning from incidents around reduced fetal movement. However, when we asked midwives and medical staff about learning from incidents they were unable to identify the learning so we were not assured it had been embedded. Whilst some staff could discuss actions from the external review the majority were unable to identify any learning.
- We had some concerns raised to us regarding underreporting of incidents. Some staff said they were encouraged to report incidents. However, some staff members said there was a blame culture and they were not encouraged to report incidents. Two staff members raised concerns regarding a recent ureteric injury not being reported. We reviewed the incident reporting system and found this incident had been reported on the electronic reporting system twice, on the day of the incident detailing major obstetric haemorrhage and urology concerns and five days following the incident confirming the ureteric injury. There was a 72 hour report for this incident and this incident was being investigated at divisional level at the time of our inspection.
- Any incidents which result in moderate or higher harm must have the Duty of Candour (DoC) according to the trust’s Incident Reporting and Investigation Policy. We reviewed two serious incidents and saw DoC had been completed for both patients.
- The service had reviewed their categorisation process for third and fourth degree perineal tears. All tears were now reported as moderate harm and a DoC letter was sent to women and any learning that was identified was shared with staff. The service also provided women with a patient information leaflet regarding care of the perineum following a third-degree tear.

Maternity

Safety Thermometer

- **We requested information regarding falls and pressure ulcers from the trust and were told there had been no falls or pressure ulcers in the last 12 months. However, this contradicted what displayed on the quality boards in the department. Therefore, we were not assured of the leadership had good oversight of this.**
- The data relating to patient pressure ulcers and falls was automatically extracted from the trust report system and presented on the nursing and midwifery dashboard. Results were displayed on Florence ward and labour ward.
- The quality board on Florence stated there had been one fall within the 12 months preceding our inspection. On labour ward they reported one fall in June 2020.
- The quality board on Florence ward there had been one pressure ulcer within the 12 months preceding our inspection. On labour ward they reported no pressure ulcers.
- There had been no cases of Methicillin-resistant Staphylococcus aureus (MRSA) within the maternity services between April 2020 and February 2021.

Is the service effective?

Insufficient evidence to rate

Evidence Based Care and Treatment

We were not assured the service always provided care and treatment based on national guidance and evidence-based practice as we found some policies were not up to date.

- Some of the guidelines we reviewed were out of date, and we found an example of guidelines with conflicting recommendations.
- The Management of Sepsis Guideline Maternity was out of date as it was due for review in August 2020. The trust told us this had not been reviewed due to COVID-19 and there were plans for this to be reviewed May 2021.
- We found one example, where a midwife had sent an email regarding the prescription of Flucloxacillin. The midwife had escalated this on three occasions and stated the medicine dosage used was not the correct dosage and therefore three near misses had occurred. The midwife said the dosage was different from what was recommended in the Updated Guidelines for the Management of Breast Abscess. We reviewed this guideline and noted it was due for review in September 2018. The guideline did not reflect the British National Formulary (BNF).
- The Caesarean Section Guideline provided detail of some of the risks which needed to be explained when getting concern from patients. However, it did not include all serious complications such as risk of Intensive Care and hysterectomy. Transfusion consent was also not included in the guideline.
- The Vaginal Birth After Caesarean (VBAC) states that vaginal prostaglandin PGE2 can be offered and is a consultant-based decision. However, in section 2.4 of the induction of labour guideline it states that a PGE2 is not recommended.
- We reviewed the shoulder dystocia guideline which was in date. However, there was no information around debrief of women and counselling for future pregnancies.

Patient Outcomes

Maternity

Staff monitored the effectiveness of care and treatment. Timeliness of reviews and implementation of change was variable, which delayed improved outcomes for women.

- In 2020 the trust reported 4,666 births and 23,690 antenatal appointments with 67.4 % of bookings being high risk. The crude still birth rates in summer 2020 were higher than comparator trusts and this triggered the service's request for a review on perinatal mortality.
- We spoke to the senior leadership team regarding the audit programme and was told the person responsible for overseeing the audit programme had left. This had left a gap over the last 12 months. The newly appointed Divisional Clinical Director (DCD) had been reviewing the governance and audit framework to improve oversight of the audit programme within the department.
- The department had taken part in the National Maternity and Perinatal Audit 2019. The trust had higher than national average emergency caesarean birth, high rate of episiotomy and obstetric haemorrhage. There were four actions from this audit and three were outstanding and had completion deadlines of May 2021. The service was continuing to monitor the indications for caesarean to ensure they are necessary.
- The National Neonatal Audit Programme (NNAP) 2020 audit report was based on 2019 data. The service's performance in the two measures relevant to maternity services was slightly better than the national rate. For the question 'Are mothers who deliver babies from 23 to 33 weeks gestation inclusive given any dose of antenatal steroids?' the unit's performance was 93% in comparison to the national rate of 91%. For the question 'Are mothers who deliver babies below 30 weeks gestation given magnesium sulphate in the 24 hours prior to delivery?' the unit's performance was 84% compared to the national rate of 82%.
- In the Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE) perinatal mortality surveillance report published in December 2020 (based on births in 2018), the case-mix adjusted perinatal mortality rate at the trust was more than 5% lower and up to 15% lower than the comparator group average including congenital anomalies. It was 5% lower excluding congenital anomalies.
- The NHS Digital Maternity dashboard provides trust level information based on data and metrics from the maternity services dataset (MSDS) and national maternity indicators.
- The maternity dashboard enables clinical teams to compare their performance on a number of Clinical Quality Improvement Metrics (CQIMS). We were provided with the dashboard from January 2021 and this benchmarked the trust regionally on a variety of clinical outcomes such as level of activity, maternal clinical indicators and neonatal clinical indicators. This told us how the trust was performing against a range of indicators against other trusts within the region. Each trust was rated 'Red', 'Amber' and 'Green' on a range of different indicators. The trust had red ratings in January 2021 for the number of caesarean sections and preterm birth rate. This was comparable with data from other units in the north west London local maternity system.
- We requested the risk of readmission for elective care and non-elective care in comparison the national average. The trust were not able to provide the data between elective and non-elective. However, readmission from the maternity dashboard between April 2020 and March 2021 was shared. There were 4116 births and 112 readmissions which was a 2.7% readmission rate.
- For the metric of babies with first feed of breast milk the trust was in the top 75% of all organisations (89.1% compared to 71.6% nationally).
- For women who had third or fourth degree tears at delivery (rate per 1,000) the trust were in the lower 25% of all organisations (16 per 1,000 births compared to 23 nationally). The trust conducted a review of the categorisation of

third degree tears in previous quarters (whereby third degree tears were recorded as low harm incidents), the Risk Management team agreed that these incidents should be categorised to moderate harm due to the potential sequelae/complication relating to perineal trauma. This was in line with national recommendations from the Royal College of Obstetricians and Gynaecologists (RCOG).

- For women who had a Postpartum Haemorrhage (PPH) more than 1500ml (rate per 1,000) the trust was in the lower 25% of all organisations (13 per 1,000 births compared to 25 nationally).
- For women who were current smokers at booking appointment, the trust was in the lower 25% of all organisations (5.3% compared to 9.4% nationally).

Competent staff

The service made sure all staff were competent for their roles, however due to staffing levels the workforce was very junior for a complex patient group.

- Staff were supported by the team of five practice educators to support staff in developing and building their midwifery skills. They were available seven days a week.
- Competency forms, supervision and assessments were in place for specialist tasks such as perineal suturing, and the administration of intravenous (IV) medicines.
- The practice educator team told us they based mandatory training on the needs of the staff and the programme is reviewed in consultation with the consultant midwife for the service.
- COVID-19 had impacted the ability to have face to face training sessions, however the team had run virtual Practical Obstetric Multi-Professional Training (PROMPT) sessions.
- Managers gave all new staff a full induction tailored to their role before they started work. Staff were provided with a comprehensive induction and preceptorship logbook which provided information in relation to the preceptorship programme, what was expected of the staff member, linked strategies, each training element of the programme, and final sign off induction and preceptorship.
- There were live skills and drills training, such as baby abduction, water births and Major Obstetrics Haemorrhage (MOH) and simulations undertaken within the maternity unit.
- There were specialist midwives for some areas such as Female Genital Mutilation (FGM), breastfeeding and safeguarding. The trust had recently introduced a reduced fetal movement midwife following learning from some serious incidents.
- A junior midwife raised concerns that they were asked to act up into band 7 coordinator roles when they did not want to and this could occur at night without support. Senior leaders told us this occurred when there were issues with staffing. They also told us this was part of the band 6 job description.
- We asked the education team regarding the appraisal rate for staffing. Compliance for both nursing and midwifery staff (77%) and medical staff (39%) was poor. We were told this was due to COVID-19.

Multidisciplinary Working

Doctors, midwives and other healthcare professionals did not always work together as a team to benefit women.

Maternity

- The ICS External Investigation identified areas of improvement which included improving Multidisciplinary Team (MDT) working and training. As a result, the trust had launched monthly MDT meetings and monthly consultant meetings on the last Friday of each month. The trust had also set up team building events and planned to open and MDT training room in March 2021.
- The trust had introduced twice daily MDT labour ward rounds. However, we were told these had only started taken place over the last two months. We observed the ward round and whilst the attendance was multidisciplinary it was mostly led by the medical staff with little input from other disciplines.
- As part of the Maternity Improvement Plan the service had conducted an audit of ward rounds and identified some actions. Actions included a handover template being devised, involvement of ward personnel in morning handover and compliance of MDT membership to be re-audited once the labour ward building works were complete.
- We observed the multidisciplinary handover and items such as patients on labour ward, triage, recover and risks were discussed. However, there was no discussion around induction of labour cases, staffing or bed capacity so we were not assured all key information was discussed.
- The Ockenden Report published seven Immediate and Essential Actions (IEA) that trusts were required to implement to improve the safety of maternity services. One action was around staff training and working together. The recommendation is that 'staff who work together must train together'. We spoke to the services practice educators who identified MDT training as one of the risks to the service as consultants were often not attending the training. We were told compliance was low for medical staffing. The senior leaders told us action had been taken to address this. The rota now factored in MDT training sessions to improve compliance from medical staff. However, this was still early in the process.
- There were some issues highlighted by staff around consultant presence in the department. On Edith ward one staff member said they needed to do a lot of chasing up to get medical staff to attend.
- The staff who worked on the Day Assessment unit (DAU) said there was good joint working between midwives and medical staff.

Is the service responsive?

Insufficient evidence to rate

Meeting People's Individual Needs

- A safety recommendation from the Health and Safety Investigation Branch (HSIB) stated the trust should ensure translation services are readily available, supported by written information when a mothers first language is not English.
- The Integrated Care System (ICS) external review highlighted that the trust should provide women who have difficulty reading or speaking English, with an interpreter who can communicate with the women in her preferred language. This should not be a member of the women's family, her legal guardian or her partner. This may be the women's advocate or link worker. Where an advocate is not available staff should utilise the telephone interpreting service.
- In December 2020, the trust had started enhanced communication support by use of an additional interpreting service and provision of phones in patient rooms. As part of further improving the trust were planning on recruiting a diversity lead midwife. The trust also had plans to appoint a maternity senior advocate and were waiting for the national job description.

Maternity

- We reviewed 10 patient records and found a section stating whether the women's first language was not English. This was completed for all 10 records. However, whether interpreters were present at all women's antenatal appointments was not being audited so we could not be assured that this was happening. The senior leadership team told us that there were plans to audit this in the future. However, they did not say when this would take place.
- The service had worked with the local Maternity Voices Partnership (MVP) to coproduce a video on reduced fetal movement in a range of different languages. The launch of this video was posted over the trust's social media account. However, not all women will have access to the internet and we were not provided with information to how the trust would mitigate this.

Is the service well-led?

Inadequate 

Our rating of well-led went down. We rated it as inadequate.

Leadership

We were not assured the leaders had the skills and abilities to run the service. We were concerned that leaders within the service were not effective in implementing meaningful changes that improved safety.

- The maternity service was managed through the trust's women's and children's division and there was a two-tier structure between the staff and the trust board. The senior leadership team consisted of a clinical director, general manager and head of midwifery. However, both the divisional general manager and head of midwifery were off sick at the time of the inspection. These posts reported to the divisional clinical director who reported to the chief operating officer. The head of midwifery also reported professionally to the chief nurse. The structure of the leadership had changed in the few months preceding our inspection so it was immature and not yet fully embedded.
- We were not assured all leaders were aware of the challenges to the service. Some leaders did not know what was on the service's risk register and there were long standing issues which had not been addressed. Some staff said leaders were not visible and did not act in a timely way to address issues within the service.
- There were mixed views from staff regarding support from the senior leadership. Some staff said they felt supported by leaders and could ask for help if required. However, a high number of staff said the leadership of the service was poor. Staff said the environment was not supportive and leaders did not deal with poor staff attitudes in an effective way. There were multiple allegations of bullying and poor culture that were long standing issues.
- We were not assured there was good medical governance within the service. Medical staffing had mixed views regarding support from the senior leadership team. One staff member said there was a split in the consultant body. Another said there was a huge discrepancy in consultant workload. One said the senior leadership team blame consultants and do not involve them in consultation regarding changes to the service. Numerous medical staff said they were afraid to speak up or when they did it was ignored and not actioned.
- The senior leadership themselves were aware that there were long standing issues that needed to be addressed. They recognised they were at the start of a journey with regards to improving the leadership and culture of the maternity services. We spoke to the chief executive officer (CEO) and medical director of the trust. They were also aware of the significant issues within maternity services. The Maternity Improvement Group was chaired by the CEO and had been running since March 2021. The executive team recognised this was very early in the journey but provided us with a detailed improvement plan.

Maternity

Vision and Strategy

- We were told by the trust that the previous Maternity Strategy was no longer relevant to the current position of the service. Following the external reviews of the maternity services, the trust developed a Maternity Improvement Plan based on recommendations from these reviews while also incorporating suggestions from the engagement work that was ongoing with staff. However, we were not assured the action plans were clearly communicated with staff. When we asked staff about these reports they could not tell us what the learning was.
- Some staff told us there was no clear vision or strategy for the maternity service.

Culture

The service did not have a culture where staff could raise concerns without fear. We were not assured concerns were progressed appropriately. There were mixed views regarding whether staff felt respected, valued and supported. We were not assured staff were always focused on the needs of the women receiving care, and the service promoted equality and diversity in daily work.

- Maternity services at Northwick Park Hospital had a longstanding systemic issue with poor culture and bullying. This had been identified as a concern at the previous CQC inspections in 2018 and 2019.
- During this inspection multiple staff raised concerns regarding poor culture and bullying. Some staff raised concerns about the certain consultants and that the leadership never challenged this or held staff to account for poor attitudes and behaviours. We were given an example of a junior midwife asking a consultant for help with a patient and the consultant refused. Another example was of individual consultants allegedly going home instead of discharging patients.
- Some staff said that there was a blame culture within the service. Multiple staff said they were afraid to speak up.
- Some staff raised concerns that the midwifery staff were not very welcoming and hostile. There were allegations of staff shouting at each other. One staff member said the culture was aggressive and not nurturing. Some senior staff were accused of bullying.
- One staff member alleged that there was discriminatory behaviour from staff to non-English speaking patients. We were given an example of a midwife shouting at a patient because she could not understand English. Senior leadership were aware of concerns around how staff treated each other and the women who used services and said they had recently started to challenge these behaviours.
- Two members of staff said despite this being a longstanding issue that the leadership had only recently started to take action. There had been some staff sessions where discussions had been held about how to challenge the hierarchy.
- Some staff raised concerns about the senior management team. One staff member said senior leaders did not seem the listen. One staff member said when concerns are raised to senior leaders regarding poor staff attitude and behaviours it is not dealt with.
- Some staff told us they were fearful to speak to us due to fear of being punished for this later. One staff member said following the last CQC report there was a backlash from the leadership team. Following the current inspection, we received two anonymous complaints that staff had been told by management to only say good things.
- During the inspection a staff member, upon entering the computer area on labour ward, mistook a CQC inspection team for a member of the unit's staff. The staff member proceeded to shout at the CQC inspector to answer the phone. We were concerned that examples such as this was indicative of poor behaviour and a culture of bullying.

- However, some staff did say they felt supported and that they could escalate concerns to medical staff if needed. Some staff said the matrons were friendly and approachable and had an open-door policy. Staff were positive about the education team.
- The trust had recently recruited a Divisional Clinical Director (DCD) who was reviewing the governance and audit framework and processes. Feedback from three staff members was positive about this appointment. Two staff members said they had noticed the trust had started to take action to address the culture since this appointment.
- As part of the trust's Maternity Improvement Plan one of the themes identified was workforce, culture and leadership. There were various action points in place to address the long-standing issues within the department. This included developing professional standards of behaviour in consultation with staff, undertaking a multidisciplinary (MDT) cultural assessment facilitated by an external team and developing a plan to address bullying within the service across all disciplines.
- The trust had implemented four staff engagement events with around 250 staff in attendance. Work had begun in developing collaboration events, which will be run by the transformation team. Each event would be devoted to one of the three themes therefore one will be focused on workforce and culture.
- The executive team were working with the General Medical Council (GMC) and Nursing and Midwifery Council (NMC) to undertake some joint workshops on professional behaviour. Health Education England (HEE) had agreed to assist with some MDT simulation events. The trust was getting a lot of external support to address the cultural issues but this was at the very start of the process. Therefore, whilst there were plans in place to address the issues at the time of the inspection it was not reflected in feedback from staff.
- We spoke to the consultant midwife who was working with the education team to run cultural safety sessions and human factors training. Cultural safety sessions had been paused from December 2020 due to the COVID-19 pandemic and infection control limitations but were due to recommence in August 2021.

Governance

Leaders did not operate effective governance processes to continually improve the quality of the service and safeguard the standards of care. However, the governance structure was new and was not fully embedded.

- The trust had appointed an interim Divisional General Manager, a new Divisional Clinical Director and an interim Clinical Governance Project Manager. The new governance structure had only been formalised a few months before our inspection and was not yet fully embedded. However, there was now a formal meeting once a month to discuss clinical governance of the maternity services which fed into the divisional clinical governance meeting.
- We asked for the last three months of the Divisional Governance meeting minutes and were only provided with one set of meetings minutes from March 2021. However, the next meeting was planned for April 2021. A range of items were discussed during the March meeting including incidents, risks, complaints and learning from deaths. The meeting was the first divisional meeting as part of the new governance structure.
- We were told by senior leaders that clinical governance meetings took place once a month. We requested the maternity services clinical governance meeting minutes and were told these took place online and no minutes were recorded. We were provided with an agenda for the Women's and Children's Division Quality and Risk Group which showed there was an hour slot for maternity to be discussed. The agenda included incidents, complaints, risk and audit. The trust provided presentation slides which had been presented during the meeting. However, as there were no minutes we could not review what was discussed during these meetings other than what was presented on the slides.

Maternity

- As part of the self-assessment following the Ockenden review the trust identified there were deficiencies in the service's audit programme which meant they were not always able to evidence the effectiveness of the service. As a result, the department was reviewing governance processes and were planning to recruit an audit midwife to improve the audit function within the department. The post has been funded and advertised. However, at the time of the inspection this was at the very early stages of the process. Therefore, there had been a lack of oversight of the services local and national audit performance. We were not assured the service was benchmarking itself nationally and action plans were in place to address any poor performance. For example, there was currently no audit taking place in triage to assess if women are seen in a time way and escalated appropriately.
- During the COVID-19 pandemic the maternity services noticed an increase in perinatal deaths between April 2020 and August 2020. As a result, the trust escalated this to the North West London Integrated Care System (ICS) for an external review. Papers were also presented to the Trust Executive Group (TEG), quality committee and trust board outlining the concerns and actions.
- The external review report was published in February 2021 and highlighted a number of areas for improvement. This included: improvements around risk assessments; access to interpreting services; identification of small babies; escalating multiple attendances; consultant involvement in complex cases; multidisciplinary (MDT) working; support for midwifery staff; MDT training; and fetal and neonatal monitoring.
- The trust identified three common themes from the review which were: workforce, culture and leadership; women-centred individualised care; and safe and effective care. From this the trust had developed 12 priority areas collated into a Maternity Improvement Plan. The plan is being monitored by the Maternity Improvement Group which was chaired by the trusts Chief Executive Officer (CEO). However, when we asked staff regarding learning from the report they were unable to articulate this and stated the report had not been shared with them. The trust had summarised the report into themes but there was a lack of clarity for staff.
- The Ockenden report identified an essential action around informed consent and women should have access to accurate information to make informed choices. Women using maternity services ethnicity at time of booking in 2020 was 61% non-white ethnic groups. Many of the women cared for in the maternity services first language was not English. The department was undertaking an urgent review of the interpreting services following a theme from some serious incidents. Some learning from serious incidents within the department was around poor access to interpreters. The leadership were aware of this but at the time of the inspection there were no audits in place to assess compliance with interpreters at each appointment.
- We had concerns regarding incident reporting within the service. Whilst some staff said they were encouraged to report incidents and learning was shared, others were unable to identify key actions as a result of serious incidents. Some staff made allegations of cover ups when things go wrong and that incidents are often not reported.
- The service displayed their quality information on the ward so that staff and patients could see the results. However, we found some information did not reflect what was found in the service. For example, the board on Florence ward said there were no missed adult resuscitation equipment checks but when we reviewed records we identified one missed check. On labour ward, patient survey data was also rated as green even though the service had collected no patient feedback which was a misrepresentation.
- The senior leaders told us there had been a lack of oversight of the audit programme since the previous person left the post. The service was reviewing the audit processes and best ways to oversee the audit programme going forward. However, we identified gaps in audits during the inspection. For example, the service was not auditing triage and had not conducted an audit of triage since 2018. Therefore, we were not assured women were seen in a timely way and escalated appropriately.

Maternity

- Following the inspection, we asked the trust for assurance it was benchmarking itself nationally. We were told there was a consultant lead for maternity audit in post who has been in post for over two years. This was contradictory to what we were told by the senior leadership team during the inspection. However, the trust had also created a new post for a full time maternity audit midwife which was currently out for recruitment.
- The leadership team identified there were some issues requiring capital funding and there were plans to address this. There was approved capital for central monitoring of CTGs which should be in place within three months which would improve safety.
- The fetal medicine services were reconfigured in February 2021 to align growth clinics, preterm clinics and fetal medicine clinics in one physical space. Women who were undergoing a Termination of Pregnancy were also within this space. We were told this change was done without consultation. One staff member raised concerns that this meant women receiving Termination of Pregnancy (TOP) were sitting in the same area as pregnant women.
- There were regular meetings with the local system to discuss maternity and the trust were planning on reaching out to the sector to recruit a director of midwifery.
- The service had safety champions in place but some staff were unable to identify who these were.
- The service had been working with the local Maternity Voices Partnership (MVP) and held weekly question and answer sessions to get feedback from all women who use the maternity services including women from black and ethnic minority backgrounds. These meetings aimed to incorporate the views of all service users to improve outcomes.
- Some of the medical staff we spoke to during the inspection said leaders did not promote a culture of quality improvement.

Managing risks, issues and performance

Leaders and teams did not use systems to manage performance effectively. They did not always identify and escalate relevant risks and actions to reduce their impact were not timely.

- The senior leadership team were able to tell us the top three risks on the service's risk register. They told us the top risks to the service were staffing, ultrasound capacity and pathology. Senior leaders were also aware of the issues around the culture in the department and had begun holding staff sessions to move the culture work forward. However, when we asked the matrons what the top risks were they were unable to tell us. Therefore, we were not assured all leaders of the service had a thorough understanding of the risk register and mitigations. However, all levels recognised the service had significant staffing issues.
- We were told by the governance lead that a new risk had been escalated around staff not asking appropriate safeguarding questions and inconsistent practice. We spoke to the safeguarding lead who informed us they had recently conducted an audit to see if women were asked about domestic violence at the time of booking. However, this was not audited at all other antenatal appointments. We reviewed patient records and found the domestic violence question and mental health question had not been asked in eight out of 10 patient records. This had been a learning point from the external review and we were not assured this risk was appropriately mitigated to keep women safe.
- Following the inspection, we requested the service's risk register and was sent the strategic risk for maternity, which forms part of the Board Assurance Framework. This risk was around the need to improve individual risk assessment and identification, to ensure that care meets individual needs. It included the need to improve workforce, team culture and leadership as well as MDT working; address vacancies that may undermine service provision and reinforce escalation processes and pathways for high risk pregnancies.

Maternity

- We were not assured the service had oversight of all risks within the department. We identified risks during the inspection that were not on the service's risk register. For example, mandatory training compliance was poor and whilst the service attributed this to COVID-19 they had not added this to the services risk register. There was poor compliance with both some safeguarding training which placed women at risk due to the complexity of the patient group.
- For medical staff, compliance was poor on multiple modules including Cardiotocography (CTG) and sepsis. The ICS external review identified CTG interpretation errors and therefore it was a risk that training compliance was still low for medical staff. This was not on the risk register.
- We identified risks around triage and induction of labour delays and escalated this to the trust following the inspection. These were not on the services risk register at the time of the inspection. However, they had since been added following escalation to the trust.
- The trust were monitoring safety recommendations from the HSIB via the service's HSIB incident tracker and were monitored by the maternity risk team. However, we were told there were plans for them to be logged on the incident reporting system as actions arising from serious incidents to ensure a stronger approach the tracking and monitoring.

Information Management

We were not assured that the service collected reliable data and analysed it effectively. Data was not always in easily accessible formats due to the multiple systems in use. Data or notifications were consistently submitted to external organisations as required, but recommendations were not always shared or implemented in a timely manner.

- Prior to the inspection we reviewed the trust's ICS external report and recommendations from the sector. There were 28 recommendations identified and the trust had divided these recommendations into three main themes.
- The trust had considered the independent review of perinatal deaths by the ICS and HSIB review within their Maternity Improvement Plan
- Following the Ockenden Review, the trust completed the Maternity Self-Assessment Document which was discussed by the Quality and Safety Committee and Local Maternity System. This had then been scrutinised by an independent panel conducted by NHS England. The issues that required focus and improvement by the maternity service were presented to the most recent trust board in March 2021. All of the actions required by Ockendon was monitored via the trusts Maternity Improvement Plan which went to the Quality and Safety Committee on the 19 April 2021 which was the day of our inspection.
- We were not assured the service had considered recent and national audit reports to inform the actions they were planning on taking to improve services. When we asked the senior leadership regarding audits we were told there had been a gap for the last 12 months regarding oversight of audits. However, they were currently in the process of reviewing this.
- The trust were planning on implementing a new electronic patient record system that was also being used in two other trusts within the ICS. This would improve joint working.

Areas for improvement

MUSTS

Maternity:

Maternity

- The service must improve compliance with mandatory training.
- The service must ensure staff practice good hand hygiene between patient contact.
- The service must ensure that the induction of women pathway is audited to ensure women are not waiting long periods of time to be induced.
- The service must ensure incidents are escalated and reported in a timely way and learning is shared.
- The service must ensure junior midwives are supported by experienced midwives on every shift to keep women safe.
- The service must ensure the sepsis pathway is followed and assess compliance.
- The service must embed the learning from the external reviews (Integrated Care Systems and HSIB), alongside the Ockenden Report and engage with the ICS and local system partners to ensure delivery of a safer maternity service and sustainable improvements in care.
- The service must ensure clinical guidelines and policies are up to date and reference the most up to date recommendations and evidence-based care and treatment.
- The service must ensure the service's risks are shared with the wider team to keep women safe.
- The service must ensure the systemic cultural issues and impact on multidisciplinary working are addressed to ensure effective working.
- The service must ensure multidisciplinary team discussions cover all key information.
- The service must maintain high compliance with daily emergency equipment checks throughout the department.
- The service must ensure the Major Obstetric Haemorrhage (MOH) trolley has daily checks completed.
- The service must implement the use of the Maternity Early Obstetrics Warning System (MEOWS) within the triage unit.
- The service must implement an audit of the triage unit to ensure women are seen in a timely way.
- The service must ensure domestic violence is being assessed at each antenatal appointment.
- The service must audit whether women are accessing interpreters at each antenatal appointment.
- The service must audit whether risk assessments are being completed for each woman and reflect accurately the woman's individual needs.
- The service must ensure there is good oversight of the audit programme.

Urgent and emergency services

Inspected but not rated

At Northwick Park Hospital, urgent and emergency care and treatment is provided in the emergency department and the urgent care centre. The two departments are co-located on the main hospital site and share an entrance and reception/waiting area. The urgent care centre is run by a primary care provider as a GP-led minor injury and illness centre. This report is restricted to the service in the emergency department only.

The emergency department accepts patients transported by ambulance or those who arrive independently. It is open 24 hours a day, seven days a week for adults and children who require emergency treatment.

From December 2019 to November 2020, the emergency department saw 115, 551 patients of which 16,029 were children.

For the year 2020, attendances fell by 22% due to the national fall in patient numbers during the first months of the COVID-19 pandemic.

Patients present to the department either by walking into the reception area or arriving by ambulance via a dedicated ambulance-only entrance.

Patients transporting themselves to the urgent care centre are initially booked onto the administration system and seen by the urgent care centre streaming nurse where a clinical assessment is completed within 15 minutes of arrival. Patients requiring to be seen in the emergency department are highlighted to the emergency department team and triage nurse who is co-located in the area. Triage is the process of determining the priority of patients' treatments based on the severity of their condition.

The department has different areas where patients are treated depending on their needs, including an urgent care centre (UCC) which was run by another provider, high dependency unit (HDU)), a rapid assessment unit (RAU), resuscitation (resus), clinical decision unit (CDU), same day emergency care (SDEC) and the paediatric emergency department (PED) with its own waiting area and bays within the department.

During the COVID-19 pandemic, the emergency department has created 'amber' and 'red' areas to minimise the risk of the infection spreading. Patients with confirmed COVID-19 are treated in 'red' areas such as resus and patients who are admitted but are unlikely to have COVID-19 are treated in an 'amber' area and tested for COVID-19 before being moved again either to a ward or discharged.

Additionally, the trust provides an integrated intermediate care service known as STARRS (short term assessment rehabilitation and reablement service) which aims to reduce hospital admissions and reduce the length of stay of patients in hospital by continuing their care at home.

We inspected Northwick Park Hospital emergency department in July 2019 as part of a comprehensive inspection. At the 2019 inspection the department was rated requires improvement overall.

We visited the emergency department during a one day focused unannounced inspection on 19 April 2021 in response to information we had received in relation to the care of patients in this department. From information we had received prior to the inspection, we had become concerned about the management of incidents, the completeness of records and the management of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions within the department.

Urgent and emergency services

We did not make changes to the ratings as this was a focused inspection and we only inspected parts of our key questions: safe, effective responsive and well led. We did not inspect caring. We used our focused inspection methodology for urgent and emergency services.

We found:

- Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
- The service generally controlled infection risk well. Staff wore the right personal protective (PPE) to keep themselves and others safe from cross infection. Patients had an assessment of their infection risk on arrival at the department and staff allocated them to the correct areas.
- 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. The service had enough medical staff to ensure safe care was provided at all times
- Staff mostly kept detailed records of patients' care and treatment. Records were clear, up to date and stored securely.
- 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.
- Patients could access the service when they needed and were able to access treatment promptly. The trust had significantly improved their patient handover and treatment time performance.
- 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.
- 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.
- Leaders and teams used systems to manage performance effectively. They identified and escalated most relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

However:

- Senior leaders were not aware of all of the risks in the department. We were told that staff were responsible for changing the filters on masks and the leadership team did not monitor this or have oversight of this. Therefore, we were not assured the filters were changed in a timely manner as per guidelines which could create a risk for both patients and staff.
- Patient safety checklists were not consistently filled in for three sets of records that we reviewed.
- Nursing staffing vacancies remained a challenge for the department. The service acknowledged that there were vacancies particularly for band five nursing staff. The department leaders had been working on recruitment in order to improve this vacancy rate. Managers regularly reviewed and adjusted staffing levels and skill mix, and regular bank and agency staff were used to fill gaps.

Is the service safe?

Inspected but not rated

Urgent and emergency services

We did not rate safe, as we looked only at specific key lines of enquiry. The previous rating of good remains.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.

- Staff we spoke with were aware of their responsibilities in relation to safeguarding vulnerable adults and children and were able to define the triggers that would prompt them to obtain a safeguarding assessment for patients.
- Safeguarding training compliance rates had improved since the last inspection. As at April 2021, nursing staff had exceeded the trust's 85% completion target for safeguarding adults level 2 at 93.9% and safeguarding children level 3 at 86.4%. 93.4% of doctors had completed safeguarding adults level 2 training and safeguarding children level 3 compliance was 78.2%. The trust told us that compliance rates for safeguarding children level 3 for medical staff was lower than the trust target due to the availability of training courses during the COVID-19 crisis. However, the trust told us that medical staff are now booked onto the courses to meet 85% compliance by the end of May 2021.
- Staff were knowledgeable about safeguarding processes. Staff in the paediatric emergency department told us they had a safeguarding flag system in place within patient records. Staff used a screening tool to assess children and double-checked details using the child protection information system. Any concerns would be escalated to the liaison health visitor and safeguarding nurses. The liaison health visitor visited the emergency department and paediatric emergency department each day to screen notes and collect any safeguarding referrals. We observed nurses assessing three patients in the paediatric emergency department and saw that a full set of observations were completed including a full social history and safeguarding screening questions were also asked.
- Between October 2020 and March 2021 Northwick Park Hospital emergency department made 419 children's safeguarding referrals and 118 adult safeguarding referrals to the relevant local authority. The safeguarding team at the hospital went through all referrals and they were discussed at the weekly safeguarding safety net meetings. Staff told us they attended the weekly safety net meeting with the hospital safeguarding team to review safeguarding referrals, outcomes and share learning.
- Staff had access to the trust's safeguarding policy and knew how to access the safeguarding team for advice and guidance when required. Staff told us the team were supportive in providing advice.
- The trust also had an off-site Independent Domestic Violence Advocate (IDVA) service that could be accessed by staff for patients if required and we were told that the IDVA team would also join the weekly safeguarding safety net meetings. As with the trust's drugs and alcohol service, the IDVA service were currently developing an animation that could be easily accessed by young people to help raise awareness of the services and support available.
- The emergency department had a policy in place for the management, referral and treatment of Female Genital Mutilation (FGM). A multi-agency referral was completed to ensure support packages could be put in place for women and their families.

Cleanliness, infection control and hygiene

The service generally controlled infection risk well. Staff wore the right personal protective (PPE) to keep themselves and other safe from cross infection.

- Staff were required to travel to work in their own clothing and once at the hospital change into a clean set of scrubs to wear during their shift. Staff changing rooms were not separated out into clean and dirty changing areas. Therefore, there was a risk of cross contamination between staff members using the changing room after finishing a shift after caring for COVID-19 positive patients and staff members using the changing room to change into clean scrubs.

However, following the inspection, the trust gave us assurances of the mitigating actions which were already in place in relation to the concerns we had around the changing rooms. The trust told us that they had sought professional advice in respect to changing areas, had conducted risk assessments and provided dedicated scrubs as an undergarment (not in direct contact) when in known contaminated areas. They also told us that there was a centralised laundry and sterilisation process to protect staff in conjunction with other measures for those removing uniforms at the end of the working day. The department also had an enhanced cleaning regime in place to minimise any residual transmission risks. The trust also told us that following our inspection, they would be implementing spot check inspections to ensure that staff were adhering to the rule of a maximum of four people in the changing facilities at any time as well as sending out a trust wide reminder about the maximum occupancy in changing facilities.

- We found all areas of the emergency department to be maintained to a high standard of cleanliness with areas tidy, clean and free from dust. We observed patient areas in the department were visibly clean. Toys had been removed from the paediatric emergency department waiting area to reduce the risk of cross contamination. We observed cleaning staff working throughout the day in all areas of the emergency department working to a standardised schedule to maintain the cleanliness of the department. We also saw staff cleaning equipment throughout the day.
- We saw that there was easy access to personal protective equipment (PPE) such as masks, aprons and gloves. The department had developed a system where patient cubicles and bays were kept as 'shells' to ensure easy cleaning and management of infection control. Equipment and PPE were kept in cupboards outside of the bays and cubicles. PPE such as gloves and aprons were available in dispensers outside of cubicles to ensure staff could put these on before entering to care for a patient. The resuscitation area had a room dedicated to the donning and doffing area for PPE.
- We found that level 3 PPE which includes gloves, FFP3 masks, gowns and visors and should be used when caring for potentially COVID-19 positive patients were easily accessible in the emergency department.
- The service used green 'I am clean' stickers to identify equipment that had been cleaned.
- Staff we spoke with told us they had received training in donning and doffing of PPE to prevent risks of cross infection. We saw that there were donning and doffing instructional posters throughout the department which staff could easily refer to. Staff told us that policies and guidance on PPE were easy to access on the hospital intranet.
- Staff told us that there were PPE champions across the department to help remind staff about good practice and changes in guidance. We were told that at every cardiac arrest there was a PPE doorkeeper champion to make sure protocols were adhered to and only the necessary people were in the room and that they donned and doffed correctly.
- Senior staff were aware of the Royal College of Emergency Medicine (RCEM) infection, prevention and control checklist tool and used it to audit the department for compliance. The department also used an additional trust audit tool to give further assurance on infection, prevention control compliance. Audits showed that the department had achieved a compliance rate of 99% in March 2021.
- A red light on the main doors to the resuscitation bays indicated when aerosol generating procedures were in progress to let staff know prior to entering the area. However, this light was not put on the other doors on the other side of the resuscitation bays.
- There was sufficient access to handwashing and drying facilities. We saw staff were 'bare below the elbow' and were using hand sanitisers when entering and exiting the unit and patient bays.
- We witnessed staff adhering to infection control precautions throughout our inspection and all staff were seen to be correctly wearing fluid resistant surgical masks covering their nose and mouth.

Urgent and emergency services

- We reviewed hand hygiene data for the department over the last three months which ranged between 70% and 80%. This was an improvement from the last inspection where results were as low as 50%.
- Cleaning information boards throughout the department showed compliance of 98%. The compliance for the environmental cleaning audit from February 2021 to April 2021 showed an average compliance rate of 98.6%.
- The department audited methicillin-resistant staphylococcus aureus (MRSA). MRSA is a type of bacteria that is resistant to several widely used antibiotics. In the last 12 months, there had been no cases of MRSA reported. In the last 12 months there had been two cases of clostridium difficile reported in the emergency department however these were community acquired infections and were not acquired within the department itself.
- Staff break rooms had signs on the doors to indicate how many staff members could safely socially distance and be in the room. We saw staff adhering to these rules.
- All staff had been fit tested for masks and there were various types of masks staff could use. This was documented on a fit testing log which was monitored by the trust centrally. Fit testing compliance was 98% for nursing staff (the remaining 2% were new staff members and had been booked for fit testing. 100% of medical staff in the department had been fit tested. New medical staff including junior doctors were fit tested as soon as they arrived at the department.
- We saw good management of sharps bins which were signed and dated. There was also good waste management and removal, including processes for contaminated and hazardous waste. This was in line with national standards.

Environment and equipment

The design of the premises kept patients safe and comfortable within social distancing rules.

- Seats in the waiting areas including in the same day emergency care area and clinical decision unit had been sealed off or had signs on them to ensure social distancing.
- An emergency trolley was available in every area of the department. They were secured with a plastic snap lock, so it was clear if someone had accessed the resuscitation equipment. Trolleys were checked daily and weekly and a log was signed to confirm checks had been made. Consumables and equipment were appropriately stored and labelled. We checked various consumables such as fluids and found them to be in date and sealed.
- Most patient bays in the department consisted of individual cubicles which meant that patients could be safely isolated if they were an infection risk. Cubicles were kept as 'shells' with only minimal equipment inside in order to reduce the infection risks and equipment becoming contaminated.
- The department had made several changes to its layout during the pandemic and changed pathways to best care for COVID-19 patients and meet the needs of the types of patients that were coming into the department. At the time of our inspection, the department was about to undergo another change in layout due to the lower incidences of COVID-19 patients being admitted to the trust. Staff were fully aware of the changes ahead and had told us they had attended consultations with the leadership team to learn more about the changes.
- The department was separated into 'red' and 'amber' areas to distinguish between patients with confirmed COVID-19 and those patients who were unlikely to have COVID-19. Patients with confirmed COVID-19 would be treated in 'red' areas such as resus and patients who had been admitted but were unlikely to have COVID-19 were treated in an amber area and tested for COVID-19 before being moved either to a ward or discharged.
- All staff treated patients as though they had COVID-19 and all patients were tested upon admission to the department.

Urgent and emergency services

- The emergency department had a waiting area for patients waiting to see the triage nurse. The waiting room had a capacity for 30 seated patients and 20 standing. Patients would be taken through to the rapid assessment unit which consisted of three 'red' chairs, four 'amber' chairs and four assessment bays.
- The 'red'/high risk areas of the emergency department were located in resus and consisted of 7 individual cubicles, one of which was used for acutely unwell children and had access to equipment for treating children.
- The 'amber'/medium risk area consisted of 35 adult cubicles which included one secure mental health assessment room and four amber resus rooms. This area was where patients were accommodated within the emergency department (ED) who required a bed while having monitoring, assessments or investigations.
- The same day emergency care ambulatory care area was in the amber area and consisted of 18 chairs in the waiting area, six bays, 12 treatment chairs and eight clinic rooms.
- The paediatric emergency department consisted of nine bays and a dedicated triage room.
- The clinical decision unit (CDU) had moved to a different area of the department since our last inspection and now had 10 cubicles and 16 seats for patients with the ability to flex up if needed. The CDU provided a short stay ward facility for patients awaiting test results or requiring observation before being discharged home. At our last inspection we found that the CDU admission criteria was not being followed and the unit was being used inappropriately for patients who required transfer to a hospital bed. At this inspection we found that the CDU was now being used appropriately and staff followed the strict admission criteria and proforma.
- Staff told us they were able to access equipment required to care for patients and were able to access computer terminals for pathology and imaging results, as well as policies and guidelines. Staff also told us that the leadership team had put in additional computer terminals which had improved access to trust systems.
- We saw evidence that equipment had been serviced and calibrated regularly. Equipment had stickers on to say when they had last been calibrated. We checked various items of equipment such as defibrillators, suction machines and blood pressure monitors and found they had been safety tested. Fire extinguishers and oxygen tanks were stored securely and were in date.
- At our last inspection we found that the service had allocated areas within the corridor for patients who arrived by ambulance. This meant that private conversations and investigations were being carried out in corridors and did not maintain patients' privacy and dignity. At this inspection, the corridors were no longer being used to care for patients. The leadership team explained that they had changed processes to ensure that patients were no longer cared for in the corridors. Patients arriving by ambulance would be assessed by a dedicated ambulance streaming doctor and cared for in the ambulance until they could be transferred straight into the appropriate area of the emergency department
- The emergency department had one dedicated mental health assessment room. At our last inspection, the mental health assessment room was in the middle of the clinical decision unit and staff had raised concerns about this. At this inspection, the clinical decision unit had been moved to a different area of the emergency department away from the mental health assessment room. The assessment room was visibly clean. The mental health assessment room was anti-ligature and minimally furnished with weighted furniture. The assessment room had CCTV and the door had viewing panels for observation. The room was opposite a nursing station where staff had access to an alarm system in the event of an emergency. The leadership team recognised that the room did not provide a therapeutic environment for patients who had to wait a long time in the emergency department and having seen an increase in mental health patients coming into the department, had put in a business case to improve mental health facilities in the department. The leadership team had drawn up a business case outlining a proposal for a self-contained mental health assessment unit to be built within the emergency department at Northwick Park Hospital. This was in the early stages however had been agreed in principle by the executive team.

- Children and young people with mental health needs were seen in the paediatric emergency department. The emergency department now had a children and young people's observation unit consisting of 4 bays. Two of the four bays were used to provide one to one observations for children and young people with mental health needs while they awaited further assessment or transfer.

Assessing and responding to patient risk

Patients had an assessment of their infection risk on arrival at the department and staff allocated them to the correct areas. Staff completed and updated risk assessments for each patient and quickly acted upon patients at risk of deterioration.

- Patients presented to the department either by walking into the reception area of the urgent care centre or arriving by ambulance via a dedicated ambulance-only entrance. The ambulance service telephoned the department to alert them of the arrival of a patient needing immediate treatment, so a team could be arranged to receive the patient immediately upon on arrival. The department had an ambulance streaming nurse and doctor at the ambulance entrance. All patients had their observations done and were streamed to different areas of the department based on risk.
- Patients attending at the front door were streamed by a trained member of the urgent care centre staff to the most appropriate area. Streaming involved taking a brief history and performing basic observations including calculation of early warning scores.
- Children who did not attend by ambulance were seen for an initial assessment by the urgent care centre staff and if they required emergency department (ED) treatment, were directed to the children's ED where triage was undertaken by a nurse. Triage is the process of determining the priority of patients' treatments based on the severity of their condition.
- All patients were assessed for their risk of COVID-19 when they entered the emergency department. For patients transported by the ambulance service, the risk assessment was undertaken when the crew member handed the patient to the ambulance streaming nurse. This helped to determine which area of the emergency department the patient was placed in to prevent the risk of cross infection. To respond to the risks associated with COVID-19, specific flow charts and a traffic light system for a patient's COVID-19 status and a risk assessment form was being used for all patient entering the department.
- All patients were tested for COVID-19 and the emergency department had a dedicated testing laboratory area where staff brought patient swabs in and a dedicated team would conduct tests. Test results could be turned around in 10 minutes.
- During our inspection we observed patients being triaged within the 15-minute expected standard. Patients were streamed to the appropriate areas of the department and observations were taken. There was a doctor within triage who assisted and supported triage nurses if required. Between April 2020 and March 2021, the average time taken for patients being streamed through the urgent care centre, to be seen in the emergency department was 36 minutes. Staff we spoke to stated that it was a challenge to meet the 15-minute triage time.
- We were told by leaders that those patients that matched the 'red flag' criteria (patients with certain conditions that require immediate attention) which was shared with the urgent care centre, would be seen by an emergency department triage nurse allocated to triage 24 hours a day, seven days a week.
- Data from the trust showed that in February 2021, 71.6% of ambulance handovers were completed within 15 minutes. The senior leadership at the trust told us the emergency department staff took clinical responsibility for patients remaining in ambulances once they had been handed over to the nurse in the dedicated ambulance triage area by

paramedics. The leadership team told us when the ambulance arrived at department, an initial handover including the infection control screen was undertaken. At this point the patient was booked onto the computer system. This process was irrespective of whether or not the patient was able to be offloaded from the ambulance. The patient was then the responsibility of the trust. However, the ambulance service retained the patient care until a space become available within the footprint of the department. A dedicated triage doctor assessed patients waiting in ambulances if they were not able to move them to a suitable bay immediately and maintained oversight of the patients who remained in the ambulance.

- There were escalation processes for ambulance staff to use which included using the National Early Warning Score (NEWS2) tool and the modified versions for children and neonates. NEWS2 is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in patients and is a key element of patient safety and improving patient outcomes. Ambulance staff would notify the dedicated ambulance triage team in the emergency department if they were concerned that a patient as deteriorating. The department conducted monthly audits looking at compliance with NEWS scores. Between October 2020 and April 2021 compliance varied between 80% and 100%. We reviewed 23 records during the inspection and saw early warning scores had been completed for all patients. The children's emergency department used an age appropriate paediatric early warning score to assess deterioration and we saw that this had been completed for the three patients that we observed who had been admitted to the paediatric emergency department during our inspection.
- There were systems for streaming children attending the department through the main waiting area of the urgent care centre once they were booked in by the reception staff. Children were directed to the paediatric waiting room where they were triaged by a triage nurse. The department had a paediatric nurse on duty 24 hours a day, seven days a week. In the last year, 0.8% of shifts were unfilled by a paediatric nurse. However, the paediatric emergency department was covered with registered emergency department nurses who had completed additional competencies and had been signed off to work in paediatrics. To mitigate the risk around the national shortage of paediatric qualified nurses, 70% of adult nurses were trained to level 2 of the Royal College of Nursing Emergency Competency curriculum which gives the competency to work in paediatric emergency departments. This exceeded the trust target of 50% trained to level 2. Emergency department nurses worked in the paediatric emergency department in their foundation period under supervision by a registered child nurse. There were two paediatric emergency department consultants who supported weekly paediatric simulation training for nursing and medical staff.
- Due to the pandemic, face to face, classroom-based resuscitation life support skills training were suspended by the trust and a recovery plan was introduced in September 2020. A recovery training plan specifically for courses in the emergency department was put in place in September 2020. The trust provided training records which showed that as of April 2021, 75% of nursing staff had completed immediate life support (ILS) training. Compliance in the paediatric nursing service was 50% for paediatric intermediate life support course (PILS) and 42% of this was for the European paediatric immediate life support. 28% of registered nurses working in the emergency department had PILS. The trust told us that ongoing training had been planned to recover the training rates which included paediatric simulation based training for nursing and medical staff which would provide an opportunity to improve medical, non-technical skills and stabilisation of the child in the emergency department.
- For medical staff in the department, compliance for adult life support training was 76%. However, the trust told us that there was a lead consultant or registrar trained in adult life support in the department 24 hours a day, seven days a week and the department had had no shifts without a staff member with this training. European paediatric immediate life support (EPALS) training rates for medical staff had a compliance rate of 46%. However, the paediatric acute team supported the department and ensured there was a trained member of staff in EPALS available in the emergency department 24 hours a day, seven days a week. The department had had no shifts without a staff member

with this training. Due to the reduced number of courses available during the COVID-19 pandemic, compliance was below the trust target however we were told that the 80% trust target will be reached by June 2021. The trust told that the trajectory for training for ILS and PILS for emergency department staff was 90% with paediatric ED staff reaching 100% compliance in a paediatric intermediate life support course by end of June 2021.

- The department used a sepsis six care bundle which was designed to offer basic interventions within first hour. We reviewed the department's sepsis screening audit which showed that in the last 12 months the trust had achieved the 90% standard for screening and initiating treatment for sepsis. The trust was using sepsis stickers in patient notes to act as a prompt to ensure the risk of not giving the correct treatment in a timely manner is reduced.
- 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. From April 2020 to March 2021 the trust reported 451 "black breaches". This was much less than the 859 "black breaches" reported at the last inspection despite the trust continuing to receive a high volume of ambulances. There were 4,686 arrivals by ambulance in February 2021 which was a reduction of 6% on the previous year. Since the last inspection the department had been continuing to work to reduce the number of breaches within the department and embed the process of the streaming nurse and doctor at the ambulance entrance. This meant that patients were seen by the streaming team and moved from the ambulance faster. The two periods with significantly increased "black breaches" were during the first and second waves of the COVID-19 pandemic. The highest number occurred in December 2020 (187). The trust told us that during this period, patients were still being treated on arrival within the ambulances by senior doctors. As at February 2021, data showed that 4.6% of ambulances remained at the hospital for more than 60 minutes which was lower than the national average of 17%.
- The leadership team recognised that the increase mental health patients was one of the challenges the department faced. The department acknowledged that there was a risk around mental health patients bed capacity and challenges around one to one observations. This had been recorded within the department's risk register with several actions in place including this issue being a standing agenda on the mental health work stream programme, an audit on enhanced observations, an enhanced mental health lead in place, daily huddles attended by the mental health team, daily review and escalation of all mental health and CAMHS patients and training for staff around enhanced care needed for mental health patients. Weekly performance meetings for mental health were in place with senior management presence.
- Since our last inspection, the department had conducted audits looking at observations of mental health patients place on enhanced observations. Data from the trust showed that the department was meeting the trust target of 80%. Between February 2021 and April 2021, the trust achieved 80% of behavioural observation charts had been completed, and 90% of risk assessments had been completed. The trust told us that to further improve upon these figures, increased teaching and spot checks were now in place.
- The leadership team had also drawn up a business plan to create dedicated mental health assessment rooms and a waiting area with a small garden in a self-contained area within the current emergency department footprint. The department was also planning to upskill healthcare assistants and registered mental health nurses to better manage the increase in mental health patients. Leaders told us that the emergency department's practice development nurses had recently organised a mental health project which helped to train staff including security guards around patients with mental health needs.
- Staff in the paediatric emergency department told us they had a good relationship with the children and adolescent's mental health services (CAMHS) team including out of hours. There were processes in place for CAMHS support out of hours. The department was also supported by youth workers who were embedded within the department supported vulnerable young adults who attended the emergency department. The trust used the young person's wellbeing guide to signpost young people to useful resources and online counselling.

- There was now a children and young people's observation unit adjacent to the paediatric emergency department which was a short stay area for children requiring further observation and investigation. Two of the four bays were used to provide one to one observations for children and young people with mental health needs while they awaited further assessment or transfer. We reviewed the risk assessments for these bays and were told that the children and young people with mental health needs were always accompanied by a health care assistant who had enhanced mental health training. Young people up to the age of 18 had the choice to be monitored in the children and young people's observation unit. Similar to what we found at the last inspection, staff did comment that a play specialist dedicated to the unit would be beneficial to helping children feel more at ease when being treated in the department.
- Staff we spoke with confirmed that they had undergone a COVID-19 risk assessment. They also told us that they were required to test themselves for COVID-19 and conducted rapid tests twice a week.

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. However, the service did acknowledge that there were vacancies particularly for band five nursing staff. The department leaders had been working on recruitment in order to improve this vacancy rate. Managers regularly reviewed and adjusted staffing levels and skill mix, and regular bank and agency staff were used to fill gaps.

- The leadership team told us that there had been an increase in nursing staffing vacancy rates due to the COVID-19 pandemic with some staff returning to their home countries and staff moving on to other departments after the initial peaks of the pandemic had passed. As at March 2021 nursing staffing turnover was 13.8%. Leaders recognised that staff turnover remained a challenge and had put this on the department's risk register.
- We requested the most recent nursing vacancy rates during the inspection. The vacancy rate as at March 2021 for band five nurses was 25.4% which was an improvement since our last inspection. However, the band six nursing vacancy rate had increased to 17.8%. The overall vacancy rate was 18.7%. The trust told us that their biggest concern was the band five nurse vacancies with 18.9 WTE (whole time equivalent) vacancies at Northwick Park. However, the trust told us that there were currently five WTE nurses currently in band four posts that would soon be able to work as band five nurses and this would improve the band 5 nursing staffing position to a total of 13 WTE vacancies.
- The leadership team told us that they had put in place actions to mitigate the pressures around recruitment and retention and that a paper was about to go to the divisional board which incorporated the latest action plans around recruitment. Plans included maintaining a named recruitment lead in the ED, continuing with advertising internally for band five rotation posts and fully recruiting to vacant healthcare assistant posts. In order to manage retention of nursing staff, there were plans for nurses to attend an internal leadership programme.
- The risk register noted that to manage the vacancies, a nurse consultant and a practice development nurse had been appointed to maintain training and work on staff wellbeing to improve retention of the nursing staff. There was also a rolling band five advert to recruit to vacant posts. There were also nursing recruitment initiatives in place such as rotation programmes and virtual open days.
- The department used the Safe Staffing Tool and the Royal College of Nursing and Royal College of Emergency Medicine Nursing workforce standards to monitor and manage their nursing workforce. During the inspection we found there were appropriate numbers of nursing staff in the department, based on number of staff and skill mix and the types of patients seen in the department. Staff reported that although there were times when staffing levels were low, the department was always able to secure bank or agency staff to cover any gaps.

Urgent and emergency services

- At Northwick Park Hospital emergency department there were two matrons, one nurse consultant, two band seven practice development nurses. The department met the requirement for 80% registered nursing staff and exceeded the minimum requirement of 50% of registered nursing staff with an academic post registration award in emergency nursing: 68% of nursing staff had completed level one and 70% of staff had completed level two.
- Staffing levels were discussed each day at safety huddles and bed meetings. Bed meetings occurred four times a day. We observed a bed meeting during our inspection and observed allocations and discussions and planning around department and hospital capacity.
- The department had a paediatric nurse on duty 24 hours a day, seven days a week. The paediatric emergency department was staffed by five registered nurses during the day and five at night supported by a healthcare assistant. There was one nurse and healthcare assistant assigned to the children's short stay area of the paediatric emergency department. In addition to register children's nurses, the paediatric emergency department was covered with registered emergency department nurses who had completed additional competencies and had been signed off to work in paediatrics. The trust reported there was a nurse trained in paediatric intermediate life support (PILS) on every shift.
- At the last inspection, we found that the clinical decision unit which at that time consisted of two room and eight chairs were staffed by one nurse only. At this inspection, the clinical decision unit which now consisted of 10 beds and 16 chairs were staffed by five nurses and two healthcare assistants, one emergency medicine consultant and a physician's associate. From 4pm to midnight, there was an on call medical consultant and from midnight to 8am there was a lead registrar on the unit.
- There were 10 Advanced Clinical Practitioners (ACP) working within the department providing support to the team. The department had support from dedicated practice development nurses who supported staff to meet competencies and complete induction.

Medical staffing

The service had enough medical staff to ensure safe care was provided at all times.

- Consultant cover was from 8am to midnight seven days a week which was in line with the recommended 16 hours per day cover recommend for A&E departments by the Royal College of Emergency Medicine (RCEM).There was also an annualised rota for consultant cover from midnight until 8am on Monday and Friday nights which were the department's busiest time. Consultants were also available on call from midnight to 8am seven days a week. Staff told us they appreciated the additional senior support at night. The paediatric emergency department had a paediatric consultant based between 10am and 10pm Monday to Friday. Over the weekend there was cover between 2pm and 10pm. Outside of those hours there was an on-call paediatric consultant.
- The department had 24 WTE consultants in post, with 4 additional consultants currently being recruited. The department met the RCEM recommendation of a minimum of 10 consultants per department and this had increased since our last inspection.
- Medical handovers took place at the start and end of each shift. Patient board rounds were held every two hours with a main board round in the morning handover. The physician in charge and charge nurse led these and went through action plans for each patient in the department along with a co-ordinator. We observed one of these board rounds in which senior multidisciplinary staff discussed every patient and performed a walkaround of the whole emergency department. Staff told us the department had a good relationship with acute medicine and we observed in-reach into the emergency department by the team. We were told speciality doctors were happy to come to the department to provide additional support.

- Medical staff vacancy rates were low at 4.8% vacancy for consultants. We were told that the consultant posts would be fully established by June 2021 pending interviews planned for five new consultants.
- Middle grade doctor vacancies were at 1.6% and the trust told us they would be fully recruited to establishment by June 2021.
- The trust had recruited to full establishment for Senior House Officers (SHOs) with a rolling advert for additional posts.
- The department had recruited to full establishment for clinical fellows with 23 additional fellows recruited as part of plans to expand the programme. The trust was creating new roles for junior clinical fellows with plans for them to spend 80% of their time working within the emergency department and 20% of their non-clinical time working on projects in their specialism such as patient safety, paediatric emergency medicine and quality improvement.
- The department had plans in place to ensure recruitment and retention could be monitored and managed effectively. There was a dedicated emergency department recruitment officer and the department worked with medical agencies to support areas that were hard to fill.
- We observed medical staff at all levels working throughout the department. Junior doctors reported that they felt well supported by senior staff and were happy with the educational and mentoring opportunities that were provided. All staff we spoke with told us they felt there was enough consultant and medical cover in the emergency department.

Records

Staff mostly kept detailed records of patients' care and treatment. Records were clear, up to date and stored securely. However, we did not find the patient safety checklist being used in some patient records.

- From information we had received prior to the inspection, we had become concerned about the completeness of records and the and lack of detail recorded within patients records within the department.
- The trust used a combination of paper and electronic patient record and there were plans to move to a paperless electronic patient record system.
- Most patient records were of a good standard and contained details of medical review, tests requested by medical staff, action plans and clear observations.
- We noted that in all 23 records we reviewed, the recording of early warning scores had been completed and pain scores had also been completed. We also saw that risk assessments were appropriately completed in patient records, such as mental health assessments, risk of falls and COVID-19 status.
- Patients who were discharged had clear and appropriately formatted letters sent to their general practitioners (GP). We saw that GP letters included appropriate clinical documentation. However, we found that patient safety checklists were not consistently filled in for three sets of records that we reviewed.
- The trust conducted an audit of the patient safety checklist on a monthly basis. The audit looked at completion of early warning scores, COVID-19 screening, medication, echocardiograms, provision of refreshments within the first two hours of arrival, pain scoring, identification bands, frailty scoring, and bloods being taken. We reviewed audit data for patient records conducted by the trust between October 2020 and April 2021 which showed good compliance on the above metrics ranging from 80% to 100%. However, the audit identified areas of improvement for the completion of skin assessment and dementia screening where compliance ranged from 50% and 75% in the same time period. The trust had implemented action plans to improve upon these areas which included additional support from practice development nurses and mental health nurses and improving communication during handovers

regarding the management of a patient living with dementia. To improve compliance around skin assessments, actions following the audit included additional support from practice development nurses and daily spot checks by the nurse in charge to check compliance. There were also plans to trial a new skin bundle assessment package to improve compliance in the emergency department.

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.

- From information we had received prior to the inspection, we had become concerned about the management of incidents within the department.
- 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 March 2020 to February 2021 the trust reported no never events for urgent and emergency care.
- From April 2020 to March 2021 there were 2978 incidents reported within the emergency department. Of these 643 were categorised as 'no harm', 1749 as 'low harm', 103 as 'near miss', 472 as 'moderate harm' and four were severe/ major harm.
- The trust used an electronic incident reporting system to report incidents. Staff were aware of their responsibilities for reporting incidents and were able to explain how this was done.
- At the last inspection, medical staff told us that they did not always get feedback from incidents however at this inspection medical staff told us they did receive regular emails around learning from incidents and that learning from incidents was better embedded into the culture of the department. The department had also launched a teaching platform in 2020 which was designed to improve teaching and information disseminated to doctors working in the emergency departments (at both Northwick Park hospital and Ealing hospitals). The system allowed staff that were not able to attend the monthly clinical governance meetings to access recordings of the meetings. The platform also allowed staff to access departmental communications such as the weekly emails sent from the clinical director, clinical governance newsletters and recordings of the monthly mortality and morbidity meetings.
- Staff told us that learning was shared through a number of ways including during online team meetings. The department also had a 'Big Four' which were four topics that were discussed each month at the meetings based on learning form incidents. Learning from incidents was shared via email, during handovers and daily safety huddles in newsletters. The emergency department had weekly newsletters which were emailed to all staff in the department which also shared learning from incidents. We also viewed monthly governance meeting minutes which discussed incidents within the emergency department.
- We viewed the minutes for monthly mortality and morbidity meetings which were held for the emergency department. We saw that the meetings provided an opportunity for serious incidents to be presented and discussed, and lessons to be learned. We reviewed the minutes which showed a good attendance by different levels of medical staff and discussions around incidents and learning. Minutes of the meetings were recorded and shared within teams and sent out in an email.

Urgent and emergency services

- The duty of candour (DoC) is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff we spoke with had a good knowledge of duty of candour and, senior staff were very clear about their responsibilities in relation to DoC.
- Staff told us they had team days every quarter to share learning from incidents. Due to the pandemic these team days had been converted to online team learning sessions. The learning was also summarised and put on the wall in the staff break section of the department so staff could refer to them.

Is the service effective?

Inspected but not rated

We did not rate effective, as we looked only at specific key lines of enquiry. The previous rating of requires improvement remains.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

The service provided care and treatment based on national guidance and evidence-based practice. Staff protected the rights of patients subject to the Mental Health Act 1983.

- From information we had received prior to the inspection, we had become concerned about the management of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions within the department.
- We observed staff obtaining consent and procedures being explained to patients. Staff we spoke with understood the importance of shared decision-making with patients. All patient records we reviewed demonstrated consent was sought and clearly recorded in the patients' notes. We saw examples of records where patients' mental health needs were recorded. Staff were aware of the trusts Mental Capacity Act (MCA) policy and how this could be accessed.
- The department undertook a review of end of life care in the emergency department as part of a quality improvement project. The review looked into improving end of life care in the emergency department during the COVID-19 pandemic and was a review which covered Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) decisions and completion, consent and involvement of consultants. As part of the project, the department produced an end of life care pathway and proforma, undertook online teaching sessions and interactive simulation to improve end of life care in the emergency department. As a result of the measures implemented, there was an improvement in the quality of end of life care offered in the department. Completion of DNACPR forms had improved from 78% to 100% and completion of treatment escalation plan forms had improved from 72% to 100%. Provision of palliative care improved from 0% to 67%; consultant involvement in care went from 72% to 83%; consideration for organ donation (if applicable) improved from 22% to 100% and a discharge letter to the GP informing them that the patient had died improved from 40% to 67%.
- In addition to this, the leadership team told us that at the height of the pandemic, they had increased staffing in the administration team so staff could get as much information about patients' next of kin so they could call and keep loved ones updated as visiting was not possible. Staff told us they were given support and there were posters on how to have a difficult conversation. They also said they used electronic tablets to help patients communicate with their loved ones and also worked with the trust chaplain.

Urgent and emergency services

Is the service responsive?

Inspected but not rated

We did not rate responsive, as we looked only at specific key lines of enquiry. The previous rating of requires improvement remains.

Access and flow

Patients could access the service when they needed and were able to access treatment promptly. The trust had significantly improved their patient handover and treatment time performance.

- At our last inspection access to beds in the hospital presented a significant challenge for the emergency department and this contributed to breaches against the department's key performance indicators. We saw significant improvements since our last inspection and staff also commented that the changes in processes had improved the flow in the department.
- The Department of Health and Social Care'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. The trust had made significant improvements in achieving this standard since our last inspection. In February 2021, the trust achieved the four-hour standard for 94.7% of patients. This was above the national average of 82.3% and was an improvement from January 2020 where this was achieved for 83.2% of patients.
- The trust had consistently improved upon meeting the four-hour standard and had been ranked between second and seventh in the country for the past six months. The department was the highest performing in London for the four-hour standard at the time of our inspection. In the week ending 18th April 2021, the trust was first in the region and eighth nationally.
- The number of patients waiting between four and 12 hours to admit into the hospital was better than the England average of 17% and was 3% in February 2021.
- There was one patient who experienced a 12 hour wait for a bed in February 2021 for patients presenting to the emergency department which was the same as in January 2020.
- During our inspection, over 100 ambulances had arrived and left the emergency department however we observed a consistently good flow and saw patients being triaged in a timely manner. The Department of Health and Social Care clinical indicators suggest that patients arriving by ambulance or self-presentation should be triaged within 15 minutes of arrival at the emergency department. Records we reviewed showed that the majority of patients were triaged within 15 minutes.
- We saw that patients arriving by ambulance were being streamed effectively by the streaming nurse and doctor at the ambulance arrivals door. There were 4,686 arrivals by ambulance in February 2021 which was a reduction of 6% on the previous year. In February 2021, 71.6% of ambulance handovers were completed within 15 minutes. 98.9% of ambulance handovers were completed within 30 minutes. During our inspection the department saw 150 ambulances on 19 April 2021 and 130 ambulances on 20 April 2021 and was the busiest site in London for ambulance conveyances for these two days. For these two days, 19% of the ambulances were offloaded after 15 mins. There were no 30 to 60-minute handover delays.

Urgent and emergency services

- 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. Since the last inspection the department had been continuing to work to reduce the number of breaches within the department and embed the process of the streaming nurse and doctor at the ambulance entrance. The two periods with significantly increased breaches were during the first and second waves of the COVID-19 pandemic. The highest number occurred in December 2020 (187). The trust told us that during this period, patients were still being treated on arrival within the ambulances by senior doctors. There were six 60-minute breaches of the ambulance handover standard in March 2021 reducing significantly from the 133 breaches reported in January. As at February 2021, data showed that 4.6% of ambulances remained at the hospital for more than 60 minutes which was lower than the national average of 17%.
- During our inspection, we attended one of the bed meetings which had senior representation and was led by site managers and the emergency department's divisional general manager where flow and bed capacity was discussed. Wait times in both the emergency department and the urgent care centre were discussed. There was also discussion about the department's capacity for the evening. This allowed the trust to identify capacity issues ahead of time and plan to ensure flow.
- Leaders were aware of the issues around flow of patients within the hospital especially during the pandemic and were engaged with the regional escalation plan if capacity within the hospital was highlighted as a concern. A mutual aid plan was available where providers in the region could support each other.
- The trust had created a Same Day Emergency Care (SDEC) service which saw up to 70 patients a day and was operational seven days a week. The service helped to reduce pressures at the front door of the emergency department and avoid the need for inpatient beds. The clinically led service had been moved closer to the emergency department which allowed for better in-reach of speciality services into the ED. The service had contributed to the hospital bed occupancy rate of 80% at the time of inspection which enabled better flow and no patients needing to be cared for in inappropriate areas such as corridors.
- The SDEC service took patients from multiple areas such as the urgent care centre, ambulatory care and GP referrals, and had a dedicated cardiac investigation suite and access to dedicated radiology diagnostic slots.
- The 'pit stop' model where patients brought in by ambulance were assessed by an ambulance streaming doctor and nurse helped move patients from the ambulance faster to appropriate areas and was embedded within the department. The department had also revised rapid assessment unit and triage processes and pathways to reduce waiting times and encourage better flow through the emergency department. This had minimised non-admitted breaches and ensured the speciality pathways could be used. This was monitored daily by the nurse consultant and discussed at the emergency department's daily performance meetings. There were agreed performance measures in place with a daily action log and a floor walker rota in place to ensure flow and to manage the demand and capacity issues. The department had also agreed with medical teams in other areas of the hospital to have 10 empty beds available to support the emergency department in times of high capacity/surge to allow patients to be directly transferred up to the wards. The department also had its own testing laboratory where patients' COVID-19 swabs could be tested, and results turned around in 10 minutes. This helped to improve flow through the emergency department and ensured patients could be moved to wards in a timely manner.
- The department's integrated intermediate care service known as STARRS (short term assessment rehabilitation and reablement service) was continuing to work well to prevent patients coming into the department if their needs could be addressed in the community.
- At our last inspection we found that patients were being inappropriately placed in the clinical decision unit (CDU) while they waited to be admitted to medical beds within the hospital. This was no longer the case and only patients who matched the strict criteria proforma were admitted to the CDU.

- However, staff did report that there were still delays in accessing beds for mental health patients. This was on the department's risk register and there were plans to improve mental health facilities within the department. The leadership team told us they had met with the local mental health trusts and escalated their concerns to the sector on a daily basis as well as having conversations around this at performance oversight meetings with the sector. Leaders told us that although the length of stay had not gone down for mental health patients waiting for beds external to the trust, patients were being seen quickly within 20-30 minutes by a doctor.
- The department also monitored on a weekly basis how long it took for patients to be seen by the ED who were streamed from the urgent care centre. Data from the first week in February 2021 showed on average there were 214 attendances at the urgent care centre, 85 of which were referred to the emergency department. 99.7% of patients were seen within four hours. On average 80% of patients referred to the emergency department were referred within two hours. In that week, 20% of patients waited more than 2 hours before being referred to the emergency department. We saw that actions had been put in place to improve performance which included a review of late referrals to the emergency department where the clinical lead was to audit the appropriateness of referrals to the ED to identify learnings and themes when numbers exceeded 5%. Learning would then be shared by email to the teams in the urgent care centre and emergency department.
- We viewed the trust full capacity protocol and the emergency department escalation pack which explained the processes to be followed at times of severe pressure. The escalation pack described what to do in various situations such as the process in the event of lack of ED capacity or out of hours escalation. It also contained information around the ED's key performance indicators, roles and responsibilities of staff and important contact details of staff across the hospital specialties. In the last 12 months, the emergency department at Northwick Park hospital had not closed due to full capacity. During the peak waves of COVID-19, the trust enacted a daily divert of ambulances between 2pm and 6pm to manage flow and avoid build up on any site. Northwick Park emergency department also received additional flow to support other hospitals in the sector.
- The trust had a Flow Improvement Programme and Improving Flow Group meeting which met every two weeks and was chaired by the chief operating officer and divisional clinical director for the emergency and ambulatory care division. At this meeting alternative care pathways were tracked in order to monitor flow across sites. The trust managed alternative care pathways through the surgical assessment unit and the ambulatory medicine unit and an additional paediatric workstream. Activity and improvements to care pathways were then tracked through the Improving Flow Group. Data showed that the increased use of the SDEC service showed that more medical patients were now being seen within SDEC rather than the emergency department and meant admissions were being avoided. The trust was also planning to use learning from the COVID-19 pandemic to develop virtual ward pathways where referrals could be made from the emergency department, acute medicine and ambulatory medicine teams. The trust planned to roll out their first virtual ward (for heart failure) pathway in May 2021 with a rolling implementation plan for other conditions following this.

Is the service well-led?

Inspected but not rated

We did not rate well led, as we looked only at specific key lines of enquiry. We did not rate well-led. The previous rating of good remains.

Leadership

Urgent and emergency services

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.

- The emergency department was part of the emergency and ambulatory care division within the trust. The division had a clinical director and clinical lead who were responsible for both Northwick Park Hospital and Ealing Hospital emergency departments. Northwick Park Hospital emergency department had its own lead nurse and matrons leading the department. Executive level accountability for the emergency department's performance was the responsibility of the chief operating officer. The medical director and chief nurse were responsible for patient safety and quality.
- The Urgent Care Centre (UCC) was managed by a different provider and not by the trust.
- The leadership team demonstrated a good understanding of their priorities. In addition to the work the team had done with regards to reducing overcrowding in the department, leaders described how they had to rapidly change their pathways as the trust was one of the first to care for a large number of COVID-19 patients when the pandemic began. The department's nurse consultant had implemented and managed the change in pathways to care for COVID-19 patients and worked with staff throughout the period to dynamically and flexibly change the footprint of the department to meet the needs of patients at the time. Leaders told us they received support from the trust in relation to infection, prevention and control and additional support from medical teams within the trust. The leadership team had implemented simulation training sessions early in the pandemic to better equip staff to care for patients who were admitted with COVID-19.
- The divisional clinical director was also the deputy medical director for the trust and reported that there was good representation for the department at board level. Staff reported visible presence of senior executives taking an interest in emergency care and regularly visiting the department.
- Leaders spoke to us about recovery plans going forward and with the incidences of COVID-19 patients at a low at the time of inspection, there was a plan to change the layout of the department again to care for the types of patients the department was now seeing. The department had consulted with staff about this change and we spoke with staff who were knowledgeable about these changes.
- During our inspection we saw senior staff members to have a visible presence within the department. Staff we spoke with told us they felt valued and felt the management team cared for their wellbeing. They spoke of a number of wellbeing initiatives the leaders had implemented throughout the year.
- Nursing staff reported to us that their matron was visible and supportive. Staff told us they were encouraged to develop and take on more senior roles.
- Clinical leadership from the consultant body was good. Junior medical staff told us consultants were approachable and present within the department. They told us they appreciated having the two busiest nights covered with consultants and felt supported by senior staff. They also commented that there were lots of mentoring opportunities provided.
- Staff at all levels were clear about their roles and accountabilities. They had regular opportunities to meet and discuss the performance of the service such as at the daily ED performance meetings. Clinical governance meetings and mortality and morbidity meetings took place monthly. There was a monthly divisional board meeting and quality and performance review where incidents and performance were discussed. These meetings fed into the trust's clinical and quality meeting which then fed into the trust board meeting.

- The leadership team described partnership working and met with the local mental health trust leads once a week where performance was discussed. There was also a mental health work stream which the trusts contributed to. There was also now an enhanced mental health lead in place within the emergency department to provide additional support with the increase mental health patients the trust was seeing.

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.

- We observed a very positive, open and honest culture within the teams across the emergency department which valued staff and was based on shared values. Staff consistently commented on the supportive and friendly teamworking environment.
- Within the emergency department staff reported that they were listened to and supported. There was respect for each member of the multidisciplinary team and the contribution they made. Medical staff told us there was a supportive culture among clinicians. Staff we met told us they felt more supported by the senior staff in the department and they were more visible and accessible since the last inspection.
- Staff we spoke with told us that even though there were demand and capacity pressures in the department especially during the height of the COVID-19 pandemic, staff morale was high and staff felt they were supported by their matrons and the team as a whole.
- The trust had a number of local and trust wide schemes that were aimed at staff wellbeing to improve morale and promote psychological wellbeing after the stress of the first two waves of the pandemic. Staff told us they had access to mental health support with a dedicated mental health nurse based in the emergency department. To further support staff wellbeing, the trust was introducing staff recovery days where staff could have a day off on or near their birthday which was not included within their annual leave allowance. The leadership team also met with the local mental health trust leads once a week and told us it was one of their priorities to drive down levels of violence and aggression from mental health patients against staff.
- Staff told us about online award ceremonies where members of the team were given awards for their contributions to the department. We viewed the emergency department's newsletters which also regularly recognised and praised the work of individual staff members as well as sharing positive feedback received about the department.
- Staff told us about virtual quiz nights and a Christmas party which they were able to attend and said that although these were held online, it boosted staff morale and brought staff closer especially at a time when the department was under a lot of pressure due to the pandemic.
- At the last inspection we were told that there was still some negative feedback about support from some staff groups however at this inspection, all staff we spoke with were positive about working in the emergency department and described supportive relationships with all members of staff. Staff we spoke with described occasions where they were supported by their colleagues inside and outside of work.
- Staff told us there were a number of opportunities for development and that they were able to shadow colleagues or do extra tasks to help with their development.
- We were shown a board in the staff break area where staff could put their names forward to become 'champions' in various areas of interest such as infection, prevention and control or wellbeing.

- Staff we spoke with were aware of the trust whistleblowing policy and were aware of the trust 'freedom to speak up' guardian.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated most relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events.

- The leadership team had made significant changes to their processes to improve patient flow and reduce overcrowding in the department. They explained how they rapidly changed pathways to best care for COVID-19 patients and at the same time also eliminated corridor care which was identified as a concern at the last inspection. Access and flow into the department had improved and this could be seen via the department's key performance indicators. Data showed that the emergency department was consistently one of the best performing emergency departments in London.
- The process of the streaming nurse and doctor at the ambulance entrance had been fully embedded and meant that patients were seen by the streaming team and moved from the ambulance faster to the appropriate areas. The regular bed meetings which discussed capacity and flow helped to ensure that the leadership team were aware of the pressures throughout the day and could escalate where needed to prevent overcrowding in the department. The creation of a Same Day Emergency Care (SDEC) service positioned next to the emergency department had contributed to the hospital bed occupancy rate of 80% at the time of inspection which enabled better flow and no patients needing to be cared for in inappropriate areas such as corridors. This was an improvement from the last inspection where patients were being cared for in corridors and the hospital was often operating at over 100% bed occupancy.
- The leadership team demonstrated that lessons learned from the first two waves of the pandemic had been embedded within the department to maintain infection control and patient care. They had developed processes where flow could be maintained, and the footprint of the emergency department could be flexibly expanded and separated according to risk and infection levels in the community.
- Leaders had identified and escalated most relevant risks and issues. However, we identified some risks that the leaders had not identified. For example, while all staff had been fit tested for masks and there were various types of masks staff could use, the leadership team told us that staff were responsible for changing the filters on masks when changes were due and that there was no oversight of this by emergency department leaders. Therefore, we were not assured the filters were changed in a timely manner as per guidelines which could create a risk for both patients and staff. Following the inspection, the trust told us that they were developing a database to ensure reminders were sent to staff when changes were due and so that leaders in the department could easily monitor this. The trust also told us daily spot checks were conducted by the COVID-19 lead in high risk/red resus areas, and reminders to staff were sent via social media groups, training days and new doctor induction days. We were told that weekly drop-in sessions were held in the emergency department so staff could access the fit testing team easily and that filter changes could be done by trained fit testers.
- We reviewed the emergency department's risk register and saw that risks for the department included nursing staff vacancy rates, lack of bed capacity for mental health patients and lack of one to one observation for mental health patients. Leaders told us that they had recently downgraded concerns about capacity in the emergency department due to the improvements that had been made through the changes in pathways and processes. Risks were shared with staff at divisional meetings, posters on noticeboards, governance newsletters and email updates. When we spoke to staff, they were aware of risks such as nursing vacancies and mental health challenges.

Urgent and emergency services

- Leaders were able to explain the changes made as a result of lower numbers of COVID-19 presentations, however, were not able to fully explain their recovery plan and plans for the upcoming winter regardless of COVID-19. We were concerned that the leadership were not able to articulate potential risks around recovery and winter plans and how they would be able to sustain the improved performance they were achieving with flow currently.
- We had concerns that the leadership team did not have full oversight of the governance processes and integration between the urgent care centre and the emergency department. Although the urgent care centre was managed by another provider, it was very much a part of the hospital with a shared waiting room, x-ray facilities and walk-in assessment point. The ED also supported the urgent care centre by pulling in patients from the urgent care centre when the number of walk-in patients increased.
- Staff we spoke with stated that it was sometimes a challenge to meet the 15-minute triage time. Staff we spoke to stated that it was sometimes a challenge to meet the 15-minute triage time due to delays from the urgent care centre streaming the patients through to the emergency department.
- We were told by leaders that those patients that matched the 'red flag' criteria (patients with certain conditions that require immediate attention) which was shared with the urgent care centre, would be seen by an emergency department triage nurse allocated to triage 24 hours a day, seven days a week.
- Leaders also said that there were joint governance meetings which took place every month with the urgent care centre. There were also joint weekly performance and catch up meetings between senior leaders of the emergency department and urgent care centre. We viewed the minutes of these meetings and saw that discussions included late referrals, redirection and challenges from the urgent care centre, new pathways and processes updates and new ED and UCC incidents. We also viewed clinical governance meeting minutes with the urgent care centre where complaints, risks and incidents were discussed. Leaders told us they deliberately ran an open-door policy without the need for a referral so that delays did not occur. The urgent care centre operational manager also attended trust daily bed meetings and the two hourly board rounds within the emergency department which reviewed lists regularly to meet demand and surge of activity. The emergency department monitored the time it took for patients to be seen and with the 'clock' starting in the urgent care centre, patients were audited as part of the overall time to be seen. There had been no incidents reported relating to this cohort of patients.
- At our last inspection, the mental health assessment room was in the middle of the clinical decision unit and staff had raised concerns about this. At this inspection, the clinical decision unit had been moved to a different area of the emergency department away from the mental health assessment room. The leadership team were very aware of the challenge the department faced regarding mental health patients. They acknowledged the one mental health assessment room was not enough with the increase in psychiatric attendances. We were told this was a top priority for the leadership team and there were plans in place to build dedicated mental health assessment rooms with a small garden within the footprint of the emergency department. This was in the early stages however had been agreed in principle by the executive team. Leaders told us that in addition to the two hourly board round, there was also 24 hour escalation routes so if there were long waiting mental health patients, this could be reported up to the chief nurse and chief operating officer as well as the deputy medical director who was also a consultant in the emergency department. In addition to this, the department had trained staff in enhanced observation, ensured that that the mental health team attended the daily huddle within the emergency department to provide support and advice on mental health patients, ensured there was easy access to the crisis team within the trust, and had appointed an enhanced mental health lead.
- The leadership team told us they had met with the local mental health trusts and escalated their concerns around mental health patients waiting for beds external to the trust on a daily basis as well as having conversations around this at performance oversight meetings with the sector.

Urgent and emergency services

- The trust was still struggling with nursing vacancy rates. Senior leaders continued to see this as one of the biggest risks in the department. However, the team had put in place actions to mitigate the pressures around recruitment and retention and had told us that a paper was about to go to the divisional board which incorporated the latest action plans around recruitment. Plans included maintaining a named recruitment lead in the ED, continuing with advertising internally for band five rotation posts and fully recruiting to vacant healthcare assistant posts. In order to manage retention of nursing staff, the leadership team plans included nursing leaders to attend an internal leadership programme. We were told that some members of the team had attended the internal leadership development training and it was planned that all nursing leaders would attend the training by December 2021. However, these were plans at the time of our inspection, and it was not possible for us to make an assessment of this. The risk register noted that to manage the vacancies, a nurse consultant and a practice development nurse had been appointed to maintain training and work on staff wellbeing to improve retention of the nursing staff. There was also a rolling band five advert to recruit to vacant posts. There were also nursing recruitment initiatives in place such as rotation programmes and virtual open days.
- At our last inspection, security presence to support staff with aggressive patients was on the risk register. At this inspection, although this was still on the risk register leaders told us that the trust had changed their security company and now had two enhanced security guards dedicated to the emergency department. The enhanced guards were in the department 24 hours a day seven days a week and had additional skills such as being able to talk down and escalate situations. Staff told us they could call upon their support at any time by dialling a specific telephone number if they were not nearby. As a result of this charge leaders told us that incidents concerning security had reduced and that they continued to monitor this with staff feedback.
- The service had a performance dashboard which particularly focused on daily demands and capacity. This enabled managers and leaders to have access to the most up to date information and make decisions effectively in real time. At the time of the inspection the daily dashboard was not working but the trust later sent us screenshots of these. The intelligence from the dashboard was discussed at daily bed meetings four times a day.
- Key performance indicators for nursing standards were tracked via trust wide ward-based application but it was not clear if this was consistently monitored or measured. However, there was a clear plan of escalation which included monitoring and diverting patients to Ealing Hospital or other London trusts if necessary, in co-ordination with the ambulance provider. Leaders were fully aware of and were engaged with the regional escalation plan if capacity within the hospital was highlighted as a concern. A mutual aid plan was available where providers in the region could support each other.
- The department had a variety of ways of getting important messages to staff including through a staff newsletter, the use of private social media messaging applications and pages, email and online team meetings. We saw posters and a quality dashboard on the walls of the emergency department. However, there were few visible patient feedback posters or leaflets to facilitate patient or friends and family feedback.
- The department had an audit programme which was used to monitor the service's compliance against national and local standards and action plans in place to address performance in some of the national audits. Quality improvement was embedded within the emergency department. Staff spoke about quality improvement projects such as for neck of femur factures, transition pathways, pain in children as well as documentation of pain scoring. Leaders reported that there was an eagerness from all staff groups to get involved in quality improvement work and that if they wanted to do a speciality based project it was easy to get a senior and junior member of staff involved from that speciality.

Urgent and emergency services

Areas for improvement

MUSTS

Urgent and emergency services:

- The service must monitor and have oversight of the changing of filters in masks that require regular filter changes to keep patients and staff safe.

SHOULDS

Urgent and emergency services:

- The service should continue to recruit and mitigate risks in relation to vacant nursing staff posts.
- The service should ensure patient safety checklists are consistently filled out in patient records.
- The service should continue to ensure recovery of training rates for medical and nursing in immediate life support training and safeguarding level 3 training for medical staff.
- The service should continue to monitor the provision of its changing facilities for ED staff in line with any ongoing requirements to minimise the risk of cross contamination between COVID-19 and non-COVID-19 areas.

Our inspection team

The team that inspected the service comprised a CQC lead inspector, one other CQC inspector and specialist advisors. The inspection team was overseen by Nicola Wise, Head of Hospital Inspection.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment

Regulated activity	Regulation
Maternity and midwifery services Treatment of disease, disorder or injury	Regulation 17 HSCA (RA) Regulations 2014 Good governance