Care Quality Commission

Imperial College Healthcare NHS Trust

Hammersmith Hospital

Quality Report

Du Cane Road,London,W12 0HS
Tel: 020 3311 3311
Website: www.imperial.nhs.uk

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

Ratings

Overall rating for this hospital	Requires improvement
Medical care	Requires improvement
Surgery	Requires improvement
Critical care	Requires improvement
Services for children and young people	Requires improvement
End of life care	Good
Outpatients and diagnostic imaging	Inadequate

Summary of findings

Letter from the Chief Inspector of Hospitals

Hammersmith Hospital is part of Imperial College Healthcare NHS Trust. It is an acute hospital and provides medical care, surgery, critical care, services for children and young people, end of life care and outpatient services. These are six of the eight core services that are always inspected by the Care Quality Commission (CQC) as part of its new approach to hospital inspection. The accident and emergency department was going to close the week following our inspection to be replaced with an urgent care centre; therefore we made the decision not to inspect it. The other core service that is not provided by this hospital is maternity and family planning. Maternity and neonatal services for this trust are reviewed in our inspection report for Queen Charlotte's & Chelsea Hospital.

Hammersmith Hospital has 346 beds and is based in the London Borough of Hammersmith and Fulham. The hospital provides a range of elective and non-elective inpatient medical and surgical services as well as outpatient services.

The team included CQC inspectors and analysts, doctors, nurses, experts by experience and senior NHS managers. The inspection took place between 2 and 5 September 2014.

Overall, we rated this hospital as 'requires improvement'. We rated effective and caring as 'good' but safety, responsive and well-led as 'requires improvement'.

We rated services for children and young people and end of life care as 'good' but medicine, surgery, and critical care as 'requires improvement'. We rated outpatients as 'inadequate'.

Our key findings were as follows:

Safe:

- Patients were asked for their consent before procedures were carried out and staff knew how to report concerns related to alleged abuse or neglect.
- The specialist palliative care team (SPCT) involved family members in decisions that related to patients' care and treatment.
- Most areas were clean and there were good infection prevention and control measures.
- Staff had received safeguarding training, was able to identify potential abuse, and were aware of how to report this.

Effective

- Pathways used for the assessment and management of patients' medical conditions were informed by appropriate national guidance.
- Patients were given pain relief when needed, prescribed in line with their individual requirements.
- There was good communication and multidisciplinary team involvement among all staff involved in patients' care and treatment.
- Pain relief was well-managed and the nutritional needs of patients were catered for.

Caring

- Staff were caring and compassionate and spoke to patients in a dignified manner.
- The privacy and dignity of patients were respected.

Responsive

- The provision in theatres was satisfactory. The surgical admissions lounge was a suitable environment and allowed for patient comfort, dignity and confidentiality.
- Single side rooms were available on wards for patients receiving end of life care and people's spiritual needs were met.

Summary of findings

Well-led

- Local line management of staff was good, supportive and visible.
- Staff worked well as a team and were motivated to do their job.
- There was an open and accessible culture that created positive teamwork among staff.
- Translational clinical research is embedded in some clinical services with close working relationships with academic departments of Imperial College.
- However, there were also areas of poor practice where the trust needed to make improvements.

The trust must:

- Correct the high number of vacant nursing and healthcare assistant posts on the medical wards.
- Address the problems associated with the administration of outpatient appointments which was leading to unnecessary delays and inconvenience to patients.

The trust should:

- Improve patient transport from the outpatients department so that patients are not waiting many hours to be taken home.
- Improve the management of medicines on the medical wards.
- Ensure patients' records are always appropriately completed.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Ensure cleaning of equipment is always carried out.
- Improve access to the one pain clinic that is available in the trust.
- Reduce the number of out-of-hours transfers and discharges.
- Monitor the clinical impact of cancellations and delays in surgery.
- Ensure that surgical patients are not cared for in inappropriate areas such as in the theatre overnight.
- Improve the responsiveness of the outpatients department with regards to clearing the backlog of GP letters from the gastroenterology clinic and reducing the waiting times for patients to get an initial appointment.
- Avoid cancelling outpatient clinics at short notice.
- Ensure there is accurate performance information from the outpatients department.
- Ensure that quality and risk issues in the outpatients department are managed effectively.
- Consider reviewing the processes for the capturing of information to help the service to better understand and to measure its overall clinical effectiveness.
- Consider reviewing the current arrangements for the provision of children's outpatient services to ensure there is parity across the hospital campus.
- Consider reviewing the operating times of the David Harvey Unit to ensure the service is accessible to the local population to which it serves, at the right time of day.

Professor Sir Mike Richards Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Medical care	Requires improvement 	The medicines storage and management arrangements were not always in line with trust policy. Staffing levels were not always adequate and shifts on some wards were not covered in order to meet patients' care and treatment needs. However, patients provided us with mostly positive feedback and felt involved in their care and treatment. We found that staff treated patients with dignity and respect. Staff were kept informed of developments at trust level and said that managers provided them with good support. The hospital achieved good clinical outcomes when compared with other hospitals, as identified through national audits.
Surgery	Requires improvement 	We found evidence of good outcomes for patients who underwent surgery at Hammersmith Hospital. There was a backlog of patients waiting for elective surgery with some patients who had experienced long waits for their surgery. The trust did provide a plan to reduce the backlog of patients waiting for elective surgery. We found preoperative assessment for some surgical specialties was not managed effectively, which often led to cancellation of elective procedures. Data submitted by the trust showed a high rate of procedure cancellation. The trust had not taken sufficient steps to ensure the 'five steps to safer surgery' – from the World Health Organization (WHO) surgical safety checklist – was embedded in practice across Hammersmith Hospital, due to the low numbers of WHO checklist audits. We identified that surgical wards had a low number of nursing vacancies; they regularly reviewed skills mix and used a low volume of agency staff. The majority of staff received mandatory training and further specialist training was available to a wide variety of staff. Infection control procedures and practices were adhered to and regularly monitored. Procedures and treatments within surgical services followed national clinical guidelines. Pain relief was effectively managed and most nutritional needs of patients were assessed and catered for.

Summary of findings

			Patients spoke positively about their care and treatment at the hospital. They told us staff were caring, compassionate and professional. Results from the NHS Friends and Family Test were better than the England average, and a high number of patients would recommend this hospital to their family and friends.
Critical care	**Requires improvement**		Critical care services at Hammersmith Hospital required improvement. We were concerned with bed capacity and staffing arrangements. Capacity was stretched and staffing levels were either not appropriate or not taking into account other arrangements in the hospital. Some aspects of safety requirements were not always adhered to. However, there was good patient feedback and good outcomes for patients.
Services for children and young people	**Requires improvement**		Both the children's outpatient department and the David Harvey Ambulatory unit were clean and tidy and there were processes in place to regularly monitor the standards of cleaning. There were procedures in place to manage the deteriorating neonate, child or young person. Whilst medical records were kept safely, there was an emerging theme that clinicians did not always have access to full sets of clinical notes or referrals in-time for clinics. Children's services followed national evidence-based care and treatment and carried out a small selection of local audits to ensure compliance. However, there was no auditing of care in which the service could be benchmarked either locally or nationally. Children and those close to them, such as their parents or carers, were involved in the planning of care and treatment and were able to make individual choices on the care they wished to receive. People spoke positively about their experience of using the David Harvey Unit, which during 2013/2014 received a very low number of complaints. Whilst the department had embraced the wider "Connecting Care 4 Children" initiative, there was little vision or future strategy for the department.

Summary of findings

There was no evidence to demonstrate that there had been consideration to alleviating the pressures of the over-subscribed outpatient department located at St Mary's Hospital.

End of life care

Good

There was an inconsistent approach to the completion of 'do not attempt cardiopulmonary resuscitation' (DNA CPR) forms. In line with national recommendations, the Liverpool Care Pathway for end of life care had been replaced with a new end of life care pathway framework that had been implemented across the hospital. Action had been taken in response to the National Care of the Dying Audit for Hospitals 2013, which found the trust did not achieve the majority of the organisational indicators in this audit, but there was no formal action plan. However, the majority of the clinical indicators in this audit were met.

There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. The specialist palliative care team (SPCT) were visible on the wards and supported the care of deteriorating patients and pain management. Services were provided in a way that promoted patient centred care and were responsive to the individual's needs. Referrals for end of life care were responded to in a timely manner and the team provide appropriate levels of support dependent on the needs of the individual.

There was clear leadership for end of life care and a structure for end of life care to be represented at board level through the director of nursing.

Outpatients and diagnostic imaging

Inadequate

The administration of appointments for the outpatients department were leading to unnecessary delays and inconvenience to patients. The number of clinics had not increased in the last year despite an increase in patients. As a result, patients had to wait longer to get an initial appointment and also to be seen in the clinic. Managers were unable to tell us the process by which they monitored performance and made improvement plans.

Staff felt supported by their local clinical managers but did not think senior managers provided the same level of support. There was very little performance information around key areas such as

Summary of findings

how quickly initial appointment letters were sent out, how long people waited in clinics and how quickly letters were sent to GPs following an outpatient consultation.
There were enough nursing and medical staff in the department to ensure appropriate care was provided. The majority of staff had completed mandatory training, including safeguarding vulnerable adults.
Patients were treated with compassion, dignity and respect. Reception staff were polite and took time to explain things to patients and their relatives.
Patients were positive about the care they received and were greeted by a 'floor walker' who ensured their specific care needs were identified and supported.

Requires improvement

Hammersmith Hospital

Detailed findings

Services we looked at

Medical care (including older people's care); Surgery; Critical care; Services for children and young people; End of life care; and Outpatients

Contents

Detailed findings

Background to Hammersmith Hospital

Hammersmith Hospital is a general acute hospital and part of Imperial College Healthcare NHS Trust. It has 346 beds. This Care Quality Commission (CQC) inspection was not part of an application for foundation trust status.

Hammersmith Hospital is in the London Borough of Hammersmith and Fulham, which is an inner-city borough located in West London. The borough has pockets of deprivation with a deprivation score of 55 out of 326 local authorities. Life expectancy is slightly lower for men and slightly higher for women than the England average.

Hammersmith Hospital is one of five Imperial College Healthcare NHS Trust locations. The trust also provides services from St Mary's Hospital, Charing Cross Hospital, Queen Charlotte's & Chelsea Hospital and the Western Eye Hospital.

Our inspection team

Our inspection team was led by:

Chair: Peter Wilde, Consultant , MRCP FRCR

Head of Hospital Inspections: Heidi Smoult, CQC

The team of 53 included CQC inspectors and analysts and a variety of specialists: consultants in emergency medicine, medical services, gynaecology and obstetrics, palliative care medicine; consultant surgeon, anaesthetist, physician and junior doctor; midwife; surgical, medical, paediatric, board level, critical care and palliative care nurses' a student nurse; and experts by experience.

How we carried out this inspection

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

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

The inspection team inspected the following core services at this inspection:

- Medical care (including older people's care)
- Surgery
- Intensive/critical care
- End of life care
- Outpatients

Please note: In this case, we did not inspect the accident and emergency department as it was going to close the week following our inspection to be replaced with an urgent care centre. Maternity and family planning and services for children and young are reviewed in our inspection report for Queen Charlotte's & Chelsea Hospital.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); NHS Trust Development Authority; Health Education England; General Medical Council; Nursing and Midwifery Council; Royal College of Nursing; NHS Litigation Authority and the local Healthwatch.

We carried out an announced visit between 2 and 5 September 2014. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients. We held focus groups with a range of staff in the hospital, including doctors, nurses, physiotherapists, occupational therapists, porters, domestic staff and pharmacists. We also interviewed senior members of staff at the hospital.

Detailed findings

The CQC inspection model focuses on putting the service user at the heart of our work. We held a listening event in the London Borough of Hammersmith and Fulham on 2 September 2014, when people shared their views and experiences of Imperial College Healthcare NHS Trust.

Facts and data about Hammersmith Hospital

Key facts about Hammersmith Hospital

Hammersmith Hospital is one of the five registered acute hospital locations of Imperial College Healthcare NHS Trust.

Context

- About 346 beds
- Serves a population of around 182,500
- Employs around 1,789 whole time equivalent members of staff

Activity

- Around 64,161 inpatient admissions (2013/14)
- Around 228,763 outpatient attendances per annum

Key Intelligence Indicators

Safety

- One Never Event in last 12 months (a serious, largely preventable patient safety incident that should not occur if proper preventative measures are taken) – a misplaced nasogastric tube in medical services (renal)
- Serious untoward incidents: There were 26 serious incidents (between April 2013 and March 2014)

Effective

- Hospital Standardised Mortality Ratios: 84 (better than national average)

Caring

- NHS Friends and Family Test: The average score for inpatients was better than the national average for 2012/13
- Response rates for inpatients was slightly worse than the national average for 2012/13
- Cancer Patient Experience Survey: The trust was in the bottom 20% of all trusts nationally for 55 of the 69 questions
- CQC Adult Inpatient Survey: The trust scored 'within expectations' in 11 out of 12 areas

Responsive

- Referral to treatment times: The Trust met the time targets for admitted and non-admitted pathways
- Cancer: two-week wait – met the national target
- Cancer: 31-day wait – met most of the national targets, apart from the target time for subsequent treatment (treatment group) surgery
- Cancer: 62-day wait – did not consistently met the national target

Inspection history

- Hammersmith Hospital was subject to one previous inspection in November 2012 and was found to be compliant with the outcomes inspected.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We have not inspected accident and emergency and maternity because these services were not provided at Hammersmith Hospital.
2. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for outpatients.

Medical care (including older people's care)

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

Information about the service

Hammersmith Hospital is a general hospital that diagnoses and treats a range of adult medical conditions. The medical wards include care of the elderly wards and specialist wards such as clinical haematology, cardiology and endocrinology. The hospital is home to the West London Renal and Transplant Centre, two large cancer treatment centres and a specialist cardiac service with an angioplasty centre. The majority of the patients in 2013/14 were treated within the clinical haematology department (35%), cardiology (23%) and nephrology (22%).

During our inspection we visited 10 medical wards. We spoke with 16 patients and two of their carers and relatives. We met with 40 members of staff, including doctors, nurses, allied healthcare professionals, ward managers, senior staff and other support staff such as cleaners or ward clerks. We reviewed patient and medication records and observed care being delivered on the wards.

Summary of findings

The medicines storage and management arrangements were not always in line with trust policy. Staffing levels were not always adequate and shifts on some wards were not covered in order to meet patients' care and treatment needs.

However, patients provided us with mostly positive feedback and felt involved in their care and treatment. We found that staff treated patients with dignity and respect. Staff were kept informed of developments at trust level and said that managers provided them with good support. The hospital achieved good clinical outcomes when compared with other hospitals, as identified through national audits.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

There was one 'Never Event' reported in June 2014. A nasogastric tube (NG tube) was misplaced, which led to an unexpected death. Medicines were not always managed safely and patients' records were not always appropriately completed. There was a high number of vacant nursing and healthcare assistant posts and occasionally shifts were left uncovered.

Patients were asked appropriately for their consent before procedures were carried out. Staff were aware of the procedures used for reporting errors, incidents and near misses and these procedures were effective. All wards were clean and there were good infection prevention and control measures. There was adequate equipment available to respond to emergencies and unforeseen events.

Incidents

- There was one 'Never Event' reported in June 2014 (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented). A nasogastric tube (NG tube) was misplaced, which led to an unexpected death. This incident occurred on the De Wardener Ward and, at the time of the inspection, was still under investigation. Staff were aware of the Never Event and knew what actions were taken to prevent future recurrence. Staff were also aware of the safety alert regarding placement devices for NG tube insertion issued in December 2013 via the central alerting system. However, staff told us that placement devices were not used at the hospital.
- Staff had access to an online reporting form and knew how to use it. Reported incidents were assigned to an appropriate service lead for investigation. The completed report was automatically sent back to the person who had reported the incident so they received feedback. There were 14 SIs at Hammersmith Hospital for the period April 2013 to March 2014. We did not have information about what number of these incidents related to Hammersmith Hospital. Nurses provided us with examples of learning from incidents. They said incidents were discussed at the ward meetings and improvements were made in response.
- The hospital reviewed deaths to ensure that patients were not dying as a consequence of unsafe clinical practices. However, there was no standardised approach to mortality review being reported to the divisional boards and to the executive committee. The mortality and morbidity meetings took place at speciality level and a senior member of staff told us issues or concerns were reported through the directorate committee meetings.
- There were 47 SIs in Medicine between April 2013 – March 2014 at Hammersmith Hospital. This information was available to the CQC.

Safety thermometer

- On most of the medical wards there was information related to the NHS Safety Thermometer clearly displayed on the walls. This was used for measuring, monitoring and analysing patient harms and harm-free care and included information related to pressure ulcers, venous thromboembolism (VTE or blood clots) and falls. A tissue viability nurse told us the trust was undertaking a learning needs analysis as a result of findings from the root cause analysis used to investigate grade 3 and 4 pressure ulcers. The analysis was due to completed in December 2014. The trust had nominated 'skin champions' and tissue viability link nurses to raise awareness among all staff. Nurses and healthcare assistants were aware of who the tissue viability nurse was and were able to contact them whenever required.
- There was a VTE lead allocated for the trust. More than 95% of patients were assessed for VTE risk within 24 hours of admission to the hospital. All patients suffering a hospital-acquired VTE were subjected to a formal root cause analysis with the responsible clinician.
- There was a medicine division safety committee at which patients' safety was discussed and actions agreed when required.

Cleanliness, infection control and hygiene

- We observed all wards, toilet facilities and waiting areas to be visibly clean. Weekly cleaning audits were undertaken by a third-party provider who was responsible for cleaning. Results of those audits were displayed on some wards. The patient-led assessments of the care environment (known as PLACE) carried out from March to May 2014 had also indicated that most of the areas within the hospital were clean.
- All observed staff adhered to good hand hygiene practice. The hand hygiene and cleaning audit was

undertaken weekly and results were displayed on the individual wards. The compliance level was often at 100%. There was a sufficient number of hand-washing basins. There were hand sanitisers available in corridors and near each of the patients' bays. Personal protective equipment, such as gloves and aprons, was available at each bay and at the entrance to single rooms. We observed that staff used this equipment to minimise the risk of spreading healthcare-associated infections.

- Patients who were infected or suspected to be infected with Clostridium difficile (C. difficile) were nursed in side rooms to prevent the spread of infection. The trust was working towards achieving the Department of Health's C. difficile target of less than 65 cases across the trust in 2014/15. There was no hospital-specific target.
- The MRSA screening compliance rate across all medical wards in the hospital was around 84% (since April 2014). One-quarter of patients who were to be tested for MRSA on Fraser Gamble Ward did not undergo the testing as required. Christopher Booth Ward reported 100% MRSA screening compliance for the same period.
- Aseptic non-touch technique audits were undertaken to ensure that only uncontaminated equipment and fluids came into contact with susceptible body sites during clinical procedures to minimise the spread of organisms from one person to another.

Environment and equipment

- Equipment such as non-invasive ventilators, cardiac monitors and infusion pumps were serviced by a qualified engineer, and suitably labelled to indicate they were operational. Nurses and healthcare assistants told us they had good access to equipment and facilities for repairs and maintenance on all wards. Equipment also appeared to be clean and was labelled to indicate it was disinfected and ready to use.
- Staff were able to respond to a potential emergency promptly as there was suitable standardised emergency equipment available on all wards. It included suction devices, face masks and oxygen cylinders. Oxygen cylinders and fire safety equipment were checked, in date and ready to use.
- All the disposable equipment (such as sterile cannulas, intravenous infusion sets and bags of intravenous infusion packs) were accessible, in date and stored in an organised manner so staff could easily find them when required.

Medicines

- Medicines were not always managed and stored appropriately on some wards. They were locked away and only authorised staff had access to them. Controlled drugs were also kept secure as advised by national guidance. We noted room temperatures, where medicines were stored, were measured to ensure the temperature was in line manufacture's recommendations. On Christopher Booth Ward the fridge temperature record indicated the maximum fridge temperature was above appropriate range at 27 degrees since June 2014. A nurse told us this was due to a problem with the thermometer which was not working properly. It was not clear if this had been reported for repair.
- When patients missed their medication it was clearly recorded including the reasons why. We noted one medication error on C8 Ward, two on D7 Ward and another medication administration error on Kerr Ward. Those incidents were appropriately recorded and investigated. In one case, a dose of trial medicine was missed as doctors and nurses were not familiar with the short expiry time for this new medication. This showed that staff did not always have the relevant knowledge related to safe administration of newly introduced medicines.
- Emergency medication and resuscitation trolleys were checked daily on all of the visited wards to ensure they were ready to use at all times.
- Doctors and nurses and told us they could contact the pharmacist whenever required and a pharmacist visited the wards daily.
- Nurses on the Fraser Gamble Ward and other wards which supported endocrinology and diabetic patients, told us that 'insulin passports' were not used at the hospital. There were no other tools used to encourage patients with diabetes to take an active role in their treatment with insulin. However, there was a diabetes specialist nurse who supported patients and clinicians in ensuring that patients received appropriate care.

Records

- We reviewed patients' records and observed that most were appropriately completed and fit for purpose. However, on Christopher Booth Ward, some of the regular patients' monitoring forms were incomplete. For example, stool and fluid monitoring charts were not fully completed for one patient. The national early

warning score (NEWS) observation chart was incomplete in another patient's file. On this ward, individual risk assessments (including falls, manual handling and skin care) were completed adequately in most cases, but some were not fully completed.
- Doctors and nurses we spoke with were aware of confidentiality and data protection procedures.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients told us that staff always spoke to them about any procedure before carrying it out. Nurses and healthcare assistants we spoke with understood that a person must give their permission before they received any type of medical treatment or examination. There was a consent policy, including guidance for medical staff on best interest decision-making when patients lacked capacity to make specific decisions.
- At the time of our inspection, there were no patients who had been subject to deprivation of liberty safeguards. Nurses were clear about the procedure they would follow to initiate the safeguards; they told us this subject was covered during their safeguarding training. However, they said that occasionally the authorisation for deprivation of liberty took a long time. On one ward, a patient had been treated and left the hospital before the authorisation had been granted by the supervisory body (local authority).
- Patients over 75 years old were routinely screened for dementia to ensure appropriate support was provided. Screening also helped to identify potential issues related to capacity to give consent.
- Clinicians were clear about their responsibilities in line with the Mental Capacity Act 2005.They explained that patients were not to be treated as being unable to make decisions unless all practicable steps to help them to do so had been taken first, without success.

Safeguarding

- Nurses and healthcare assistants told us about the safeguarding vulnerable adults training they received and how this was refreshed annually. Nurses had been appropriately trained up to level 2.
- Staff working at the hospital were aware of the procedure they should follow if they suspected abuse was taking place and how to report it appropriately. Some nurses were able to tell us about safeguarding alerts they had made and the outcomes for the patients concerned.

Mandatory training

- Nurses said they were up to date with their mandatory training which included basic life support, safeguarding, information governance, mental health awareness and health and safety training. When they started working at the hospital, they undertook an induction process which included a corporate induction and e-learning modules.
- The trust target for mandatory training compliance was 95%. Nurses working in the infectious diseases department had completed their mandatory training. Compliance with mandatory training for nephrology, and gastroenterology were at about 50%, whilst compliance for clinical haematology was: D7 50%, Dacie 95.83% and Weston 68.75%.
- The trust reported that between 67% and 82% of doctors working within nephrology and clinical haematology had completed their mandatory training.

Assessing and responding to patient risk

- Staff carried out hourly comfort rounds for all patients who needed them and recorded this activity in their medical records. This allowed nurses to recognise if a patient's health had deteriorated and to escalate promptly whenever required.
- We saw that patients had call bells within their reach and patients told us their calls were promptly answered by staff whether day or night.
- The national NEWS system was used across the hospital to assist staff in the early recognition and escalation of a deteriorating patient. We saw that NEWS documentation was appropriately completed on all wards, with the exception of Christopher Booth Ward. The Situation-Background-Assessment-Recommendation (SBAR) framework (a technique for communicating a patient's condition) was used to help staff escalate any concerns in a clear and concise manner.
- Most of the individual risk assessments for patients were up to date and reviewed when required. This included falls assessment, use of bed rails or pressure ulcers risk assessment. On Christopher Booth Ward, some of the risk assessments were not fully completed, and others were not reviewed weekly as required. Out of five patient records we reviewed on the ward, two did not have falls, nutritional or manual handling risk assessments. Another risk assessment had not been reviewed for 11 days.

Medical care (including older people's care)

Nursing staffing

- Senior nurses told us that staffing levels on the individual wards were established to reflected patients' acuity and dependency. However, a high staff vacancy rate was included as a moderate risk on the divisional risk register. Some wards were unable to fill shifts with temporary staff, particularly at short notice. A senior nurse on Fraser Gamble Ward, who was supposed to be supernumerary to the team, said that sometimes they were required to fill an uncovered shift. Nurses on Christopher Booth Ward told us that occasionally they were required to cover shifts on other wards, which left their ward short-staffed. They said this had put additional pressures on their colleagues and potentially affected the level of care. During the week of the inspection, there were three days when day shifts for nursing staff were left uncovered on Fraser Gamble Ward. A matron told us that weekly teleconference calls were organised to discuss staffing needs and decide on staff redeployment if there was a need.
- There were nursing staff vacancies within all medical specialities at the hospital. Acute medicine had the highest vacancy rate among nurses (25%) followed by elderly medicine (22%) and the infectious diseases department (17%).
- For June 2014, the agency WTE used, shown as a % of the operating WTE for the following wards were: elderly medicine 0.33%, infectious diseases 2.06% and specialist medicine 1.62%
- The specialist medicine department had the highest absence rate (10 for healthcare assistants) with other specialities recording absence rates below 6%.
- Staffing requirements were not fully met in June 2014 on the B1 Ward, with 13% of nurses and 22% of healthcare assistants' day shifts left uncovered. Similarly on John Humphrey Ward, 13% of nurses' day shifts were left uncovered. Only 73% of healthcare assistants' day and night shifts were covered during the same month on De Wardener Ward. Weston Ward also had problems with covering planned shifts; only 69% of day, and 77% of night shifts for healthcare assistants were staffed.
- In August 2014, B1 Ward beds were reallocated to C8 Ward. Although a senior nurse told us they were able to provide adequate staff to meet patients' needs, staffing levels had not been reviewed and adjusted prior to the move. The number of beds had increased from 12 to 20 with 17 beds occupied at the time of the inspection. This had put additional pressures on staff working on the ward.

Medical staffing

- There were no consultant vacancies within cardiology or nephrology departments. We noted that 20% of consultant posts within the elderly medicine were vacant, although this did not have a negative impact on the outcome of patients' care and treatment.
- The trust reported a 20% vacancy rate for trainee doctors in elderly medicine and 16% for acute medicine. There were no trainee doctor vacancies for cardiology.
- We noted a low absence and sickness rate among doctors for all medical specialities.

Major incident awareness and training

- There was a site-specific major incident plan approved in December 2012. It clearly listed call-out and communication procedures as well as command and control teams. Action cards had been developed to assist various staff in taking control and coordinating actions in the event of a major incident. Staff were provided with the contact details for local emergency services and neighbouring hospitals.

Are medical care services effective?

Good

Treatment provided to heart attack patients, where the supply of blood to the heart was only partially blocked, was significantly better than the England average. Care pathways used for the assessment and management of patients' medical conditions were informed by appropriate national guidance. Patients were given pain relief when needed and this was prescribed in line with individual requirements. There was good communication and multidisciplinary team involvement among all staff involved in patients' care and treatment.

Evidence-based care and treatment

- The trust used audit tools as advised by the National Institute for Health and Care Excellence (NICE) for the assessment and management of patients' medical conditions. Audit tools aided the implementation of the NICE guidelines. In autumn 2013, the trust had

participated in the audit organised by the British Association of Dermatologists to assess treatment of patients with psoriasis. In November 2013, the trust audited how NICE guidelines were related to orthoptic involvement in post-stroke visual impairment. Stroke prevention and management guidelines were informed by the 2012 National Clinical Guideline for Stroke published by the Royal College of Physicians and NICE guidance for the prevention of vascular occlusion (blockage of blood vessels).

- There was a process for reviewing out-of-date clinical guidelines. Any updates to procedures and clinical guidelines were discussed at the medicine division safety committee.

Pain relief

- Patients told us they had been given information about pain management and said nurses regularly checked them to make sure they were comfortable and were offered pain relief when needed. They said nurses administered pain relief medicines as prescribed and advised them on side effects.
- There was a pain measurement tool used in the hospital which formed a part of the assessment process for patients with dementia and was part of their hourly comfort checks completed by ward staff.

Nutrition and hydration

- Patients told us that staff provided them with food on request during the day or night. A few patients said the food was "a bit tasteless" and that the soup was "not served hot". We observed lunch on the ward: nurses and healthcare assistants informed people what the food was as they served it; and there was a system to alert staff to any patient who needed assistance.
- The PLACE assessments carried out from March to May 2014 indicated that the food served to patients at the hospital had been 'good' or 'acceptable'. This assessment noted that patients were not always offered the chance to clean their hands prior to the food service and sometimes patient areas were not prepared for the meal service. However, we saw that patients had hand wipes by their beds. The trust had prepared an action plan and addressed issues highlighted in the PLACE assessment.
- There was a catering services folder available on each ward setting out the full range of services available and how to access them. Menus were varied and catered for patients' cultural preferences.
- Food and fluid intake charts were mostly accurate and up to date, and patients' nutritional needs were monitored appropriately. On Christopher Booth Ward, two patients did not have accurate nutritional risk assessments. One patient had refused food for two days but the reason was not clearly recorded and it was not clear what actions had been taken by staff to support the patient with this issue.

Patient outcomes

- The hospital was one of the eight designated pulmonary hypertension centres in the UK. The hospital participated in the National Pulmonary Hypertension Audit with a view to improving clinical care and obtaining best outcomes for patients with this illness. Because of the specialist nature of this treatment and lack of comparable data, we were unable to assess its effectiveness.
- The information from the Myocardial Ischaemia National Audit Project (MINAP) suggested that treatment provided to patients with a heart attack, where the supply of blood to the heart was only partially blocked, was significantly better than the England average. This is a national clinical audit of the management of heart attack covering the period between April 2012 and March 2013.
- The hospital had performed worse than the England average in the National Diabetes Inpatient Audit, (September 2013) in 11 out of 21 measures. The audit also suggested that, on occasions, staff were unable to provide the emotional support patients required or answer their questions related to their illness.
- The hospital participated in the National Heart Failure Audit 2012/13 which collects data on patients with an unscheduled admission to hospital who are discharged with a primary diagnosis of heart failure. The hospital performed better than the England and Wales average in seven out of 11 indicators. This audit indicated that 89% of patients had input from specialists, and nearly all patients had received an appropriate discharge plan. Patients had also been referred to cardiology for a follow-up appointment. However, there were fewer-than-expected patients who were referred to a heart failure liaison service.
- Hospital Standardised Mortality Ratio (HSMR) indicators were lower than expected for October 2012 to September 2013 for both weekday and weekend stays.

Medical care (including older people's care)

- We observed in elective cases that there were better emergency readmissions than expected (100) for clinical haematology (74) in 2013/14, when compared with the England average (patients who return to hospital within 28 days post discharge from hospital). In other specialities such as nephrology (115), and cardiology (116), it was worse than the expected.
- For non-elective treatments in clinical haematology the readmission rate was much better (63) when compared with the England average (102). However, it was worse than expected in nephrology (106) and cardiology (113).
- Overall the hospital's readmission rate for all elective and non-elective treatments (101 and 103 respectively) was within expectations. The head of speciality and a general manager told us that readmission rates reflected the nature of specialist treatments offered to patients and the complexity of cases treated at the hospital. We noted that senior clinicians could not provide full insights into variances in readmission rates within cardiology and nephrology.

Competent staff

- Senior nurses told us that supervision or one-to-one operational meetings were organised on a "when required" basis.
- The trust was in a process of implementing a new staff personal development programme. Most staff had been appraised in 2013 or at the beginning of 2014 using the old programme. Senior nurses told us they were still waiting to receive training in how to use the new appraisal system.
- There was a competency framework for new staff, which was completed within the first three to six months of their employment in the service.
- Trainee doctors told us they were generally satisfied with the support they received from the trust.

Multidisciplinary working

- There was good multidisciplinary team involvement. We observed ward rounds where allied healthcare professionals and other specialists were involved to ensure the delivery of care was appropriate and effective. Patients' records indicated there was appropriate and timely input from the multidisciplinary team.
- Nurses told us there was adequate access to physiotherapy and occupational therapy and there was good pharmacy support on all wards.
- The hospital had a consultant-led team called the older people's assessment and liaison team which was available 24 hours and ensured that older people's needs were specifically identified on admission.

Seven-day services

- Pharmacy services were available out of hours to allow prompt discharge.
- Matrons told us the staffing levels set to provide care at night and during weekends were adequate.
- Junior doctors and nurses told us they had adequate support from consultants or specialist registrars out of hours.

Are medical care services caring?

Good

Staff were caring and spoke to patients in a dignified way. Patients told us doctors and nurses were friendly and polite and they felt involved in decisions about their care and treatment. The shortage of staff on some wards meant that some were not adequately staffed to meet patients' care and treatment needs. However, there were arrangements to provide emotional support to patients.

Compassionate care

- Staff told us that the shortage of staff on some wards meant that some were not adequately staffed to meet patients' care and treatment needs.
- Patients told us staff were "helpful, generous and always answered the calls". One patient said staff were "wonderful, I couldn't praise them enough" and "they say if there's anything you need, just ask". Another said, "I am like a member of family; staff came from another ward specially to visit me". We observed patients being treated with compassion, dignity and respect.
- We saw that nurses and healthcare assistants greeted patients and introduced themselves by name and engaged patients in conversations.
- The hospital's results for the NHS Friends and Family Test for 2013/14 showed eight out of 12 wards often scored better than the England average. Kerr Ward was among the highest rated wards. Fraser Gamble Ward received the lowest scores and was below the England average for nine out of 10 months of the test results.

Medical care (including older people's care)

- There were low response rates for the test on some of the wards (below 20%). The trust was working towards improving the response rate to 40% across the hospital by March 2015.

Patient understanding and involvement

- Nurses and healthcare assistants told us how they involved and listened to patients and their family members when they gave feedback about their care and treatment. We observed family members being involved in discussions with nursing staff about their relatives.
- Staff were attentive to patients' needs. We observed them speaking reassuringly to patients, explaining their treatment and seeking their consent. Doctors and nurses explained procedures to patients in simple words and answered their questions. Most patients told us they felt involved in decisions about their care and treatment.
- Patients knew how they were progressing with their treatment, who was in charge of their care, and when they were due to be discharged.

Emotional support

- There was a counselling service open to patients, family members and carers of the West London Renal and Transplant Centre. It provided psychological and emotional support to patients who had a kidney disease. The centre's staff were also involved in the Hammersmith Hospital Kidney Patients' Association – a support group and charity run by patients with kidney problems, their families, friends and carers. All patients under the care of the centre were automatically members of the association and received the National Kidney Federation's quarterly magazine.
- The pulmonary hypertension service at the hospital – which was run by patients for patients and their carers – had close informal links with the Pulmonary Hypertension Association.
- The hospital had developed close links with the local branch of the Multiple Sclerosis Society, which provided support, care and financial assistance for anyone who was affected by MS.

Are medical care services responsive?

Requires improvement

Medical services provided patients with care that was not always responsive. There was a number of out-of-hours transfers and discharges.

There was good cooperation across the hospitals and divisions to manage bed capacity issues and there was a low number of medical patients who had to be treated on other types of wards because of a lack of medical beds.

Service planning and delivery to meet the needs of local people

- Staff on most wards said the bed occupancy level was very high and all beds were occupied most of the time. However, the trust did not provide us with full information related to bed occupancy rates. Site operation managers were leading on capacity issues and worked in close partnership with a senior site nurse practitioner.

Access and flow

- There was a patient flow coordinator who worked alongside the head of site operations, site operations manager, and site nurse practitioner to address any flow and bed capacity issues.
- There was a number of patients transferred or discharged from the hospital at night time (between 10pm and 7am). From June 2014 to August 2014, 243 patients were transferred to another ward out of hours, mostly from cardiology, nephrology or gastroenterology, and 240 patients were transferred to another hospital out of hours. In the same quarter there was a number of patients (336) discharged out of hours, mostly from cardiology, clinical haematology and nephrology departments.
- The average length of stay for the hospital in 2013/14 was in line with the England average for elective cases (four days). Cardiology patients stayed for about one day, which was shorter than the England average (two days). The length of stay for clinical haematology and blood and marrow transplantation patients was slightly longer than the England average (nine and 27 days respectively, versus the England average of seven and 24 days).

Medical care (including older people's care)

- The average length of stay for non-elective cases was one day longer when compared with the England average of seven days. Cardiology patients' length of stay was in line with in the England average. For nephrology (10 days) and clinical haematology (10 days) patients it was longer than the average for non-elective cases (seven and six days). Senior clinicians could not fully explain why variances in length of stay rates occurred within those two specialities. They told us it was due to the specialist nature of the treatment provided by the hospital.
- The number of patients who were placed in other departments' wards due to the lack of beds (medical outliers) varied between 117 patients in July 2013 to 23 in June 2014. It was mostly renal (nephrology) patients who were placed on non-specialist wards. Both doctors and nurses said it was clear who coordinated the care and treatment of patients who were placed in other departments. Nurses said they were able to contact the responsible consultant when required and thought outlying patients received adequate support.
- The average length of stay for medical patients was within expectations. On the day of inspection there were 169 medical patients at the hospital. Most of them (77) had stayed for no longer than three days. Eleven patients had been admitted for more than 28 days. The average length of stay for patients who were admitted for longer than 10 days was 27.6. Only one patient at Fraser Gamble Ward had stayed for an excessively long period of time (128 days) due to difficulties with arranging a nursing home placement.

Discharge planning

- Nurses told us that occasionally the discharge process was slow. They said there was no discharge lounge and patients were required to wait for transport and medicines on the ward and unnecessarily occupy a bed. Some nurses mentioned there were delays linked to administrative processes such as faxing documents or communication with other professionals and external providers involved in the patients' care.

Meeting people's individual needs

- Written information on available support services, various medical conditions and how to minimise the risk of infection was available for patients and their families. However, no other communication tools, such as pictorial versions of the menu, were available to support people with limited communication.
- The majority of the people who live in Hammersmith and Fulham speak English, but there are also large French, Somalian, North African Arabic and Spanish-speaking communities. Doctors and nurses told us they had good access to translation services and were able to communicate with patients who did not speak English. They could contact an interpreter over the phone during the day or night. The hospital had several spiritual and religious facilities which included a Christian chapel and Muslim prayer room. Representatives of various faiths could be contacted by patients when required.
- The PLACE assessment carried out from March to May 2014 had indicated that hospital signs did not always clearly identify all important and regularly used parts of the hospital, such as wards, outpatient areas, emergency departments, or the pharmacy. We also saw that it was difficult to find areas due to poor signage across the hospital.
- We met with a dementia specialist nurse who worked across the trust sites and provided staff with support and information relating to dementia care. They said that, since 2011, they were involved with dementia awareness face-to-face training for about 3,000 of nurses, healthcare assistants and doctors across the trust. We were also told the training provided had "translated into better dementia care provided to patients". The nurse said screening for dementia was routinely completed for all patients who were aged 75 or over and admitted as an emergency for 72 hours. There was limited awareness of the 'This is me' tool introduced by the trust to share information about patients living with dementia, their likes and dislikes as well as their social history and background. Nurses and healthcare assistants told us it was not fully implemented in the hospital.
- People living with diabetes did not have 'insulin passports' or diabetes-specific care plans in order to help them be more active in their own treatment.
- Some patients were admitted for a lengthy period of time (up to 128 days) with limited access to day activities or entertainment such as television or radio at their bedside. There were limited facilities to provide day activities on most of the wards.
- Patients told us they were happy with the visitor times set. Some said staff were very flexible as "visitors can come anytime".

Medical care (including older people's care)

Learning from complaints and concerns

- There was an effective complaints system available. Comments and complaints from patients were responded to appropriately. Few formal complaints were received by the hospital from medical patients in 2014.
- Leaflets were displayed on all wards informing patients how to raise concerns and provided them with information on Patient Advice and Liaison Services (PALS). Information about how to make a complaint was also available on the trust's website.
- Senior nurses told us they tried to resolve issues locally whenever possible and, if unable to do so, they were encouraged to direct service users to the PALS.

Are medical care services well-led?

Requires improvement

Full-time managers had not been in post on Kerr and Handfield Jones Wards between 22 March and 1 August 2014. Staff were kept informed of developments at trust level and felt listened to by their line managers. They felt satisfied with the quality of their work and were motivated to do their job. Staff were able to express their concerns and worked well as a team. While the results of the NHS staff survey were positive in many areas, the results could not be broken down to ward level to identify specific issues in some areas.

Vision and strategy for this service

- Staff were aware of the name of the chief executive and some of the board members. They said the board members worked in a transparent way and were "seen around the trust."
- Staff confirmed they had been kept informed of developments at trust level through emails and newsletters. They were encouraged to participate in reviewing the trust's vision and strategy. In July 2014, the chief executive and executive and divisional directors hosted staff meetings where the clinical strategy and service transformation plans were discussed.
- There was a staff newsletter where the trust's vision and objectives were publicised.

Governance, risk management and quality measurement

- There were systems to monitor risks and quality of the service. Regular medicine division safety committee meetings were attended by managers from the hospital. Risks related to different specialities were discussed at the meeting and outcomes shared with the trust's quality and safety committee. Individual medical specialities quality and safety meetings were held and outcomes from those meetings were also shared with the medicine division safety committee.
- There were regular senior nurses meetings held in addition to ward meetings where risk and governance issues were discussed.

Leadership of service

- Nurses and healthcare assistants said they felt supported by their line managers, and local managers were visible and engaged. Staff on Kerr and Handfield Jones Wards said the trust had not appointed a manager to those wards for nearly six months. In fact a full-time manager had not been in post between 22 March and 1 August 2014.
- Most of the doctors, nurses and other healthcare professionals told us they felt involved in the management decisions that affected their day-to-day jobs. They felt consulted on issues regarding service delivery and quality improvements.

Culture within the service

- Staff we spoke with were patient-centred and aimed to provide "the best quality care".
- The key findings from the national training survey carried out by the General Medical Council in 2014 found that trainee doctors were 'overly satisfied' (80%) with working for the trust. This survey also indicated the culture within the service was good. The trust was unable to tell us how the survey results corresponded to individual hospital wards.
- Overall, as indicated by the NHS Staff Survey 2013, staff felt more satisfied with the quality of their work and well-motivated at work compared to other trusts. The trust was unable to tell us how the survey results corresponded to individual hospital wards.

Public and staff engagement

- The hospital engaged patients by asking them to respond to the NHS Friends and Family Test and to use

the 'I track' electronic survey devices to record their feedback. They also took account of comments made by the PLACE assessment team and responded to those appropriately.

- There was a Friends of Hammersmith Hospital group formed of volunteers who helped to raise funds to purchase hospital equipment and other activities. The group organised two raffles annually, one in May, and one in November. These were supported by patients, staff and visitors. In 2013 the group funded art therapy sessions in the renal dialysis wards. In 2014 they were raising funds to purchase additional plasma exchange equipment for the benefit of dialysis patients being treated by the renal department.

Innovation, improvement and sustainability

- There were examples of innovation and improvement working both in the hospital and with other stakeholders and providers to improve patient care. Such as doctors and nurses were working in close cooperation and visiting other hospitals to teach staff about the importance of caring for the veins of renal patients. As part of the campaign, the Imperial team and patients visited local hospitals and dialysis units across North West London to teach staff and patients how to improve 'vascular access in patients requiring dialysis.
- Cardiac care department supported by the 'Friends of Hammersmith Hospital' were to introduce an innovative and complex rhythmia mapping system to support treatment of complicated heart rhythm disorders (cardiac arrhythmias) in September 2014. The '3D technology' system maps electronic signals of the heart and can identify more accurately disorders in all four of the heart's chambers, more accurately and quickly than other systems.

Surgery

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

Information about the service

Hammersmith Hospital provides specialist surgical services, including cardiac, gynaecology, haematology, hepatobiliary (liver, gall bladder and bile ducts) and pancreatic surgery. Of the surgical procedures carried out in the past year, 18% were day case procedures, 51% were elective and 31% were emergency cases.

There were 56 beds in the designated surgical wards. Wards A6 and A9 ware specialist cardiothoracic wards and ward A8 is a specialist hepatobiliary and pancreatic surgery ward. There are eight elective and emergency theatres across the hospital, which includes dedicated cardiac theatres. There is also a private patient's ward, in the Robert and Lisa Sainsbury wing, which we did not visit during our inspection.

We spoke with seven patients, observed care and treatment and looked at four care records. We also spoke with 18 staff members at different grades, including allied healthcare professionals, nurses, doctors, consultants, ward managers, matrons and members of the senior management team. We received comments from our listening event (on 2 September 2014) and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

We found evidence of good outcomes for patients who underwent surgery at Hammersmith Hospital. There was a backlog of patients waiting for elective surgery with some patients who had experienced long waits for their surgery. The trust did provide a plan to reduce the backlog of patients waiting for elective surgery. We found preoperative assessment for some surgical specialties was not managed effectively, which often led to cancellation of elective procedures. Data submitted by the trust showed a high rate of procedure cancellation.

The trust had not taken sufficient steps to ensure the 'Five steps to safer surgery' – from the World Health Organization (WHO) surgical safety checklist – was embedded in practice across Hammersmith Hospital due to the low numbers of WHO checklist audits. We identified that surgical wards had a low number of nursing vacancies; they regularly reviewed skills mix and used a low volume of agency staff. The majority of staff received mandatory training and further specialist training was available to a wide variety of staff. Infection control procedures and practices were adhered to and regularly monitored.

Procedures and treatments within surgical services followed national clinical guidelines. Pain relief was effectively managed and most patients' nutritional needs were assessed and catered for.

Surgery

Patients spoke positively about their care and treatment at the hospital. They told us staff were caring, compassionate and professional. Results from the NHS Friends and Family Test were better than the England average, and a high number of patients would recommend this hospital to their family and friends.

Are surgery services safe?

Requires improvement

The trust had not taken sufficient steps to ensure that the 'Five steps to safer surgery' was embedded in practice across Hammersmith Hospital. Recent serious incidents involving a retained swab had occurred at St Mary's Hospital and another 'Never Event' at Charing Cross Hospital both involved incomplete or ineffective use of the WHO surgical safety checklist. Therefore, we were not assured that surgical procedures were sufficiently safe across the trust.

Serious incidents were investigated. Ward areas were well-staffed and daily consultant-led care was also embedded. Staffing levels and skills mix were maintained and use of acuity tools were used in practice.

Incidents

- There was a process for investigating Never Events and patient safety incidents, including serious incidents requiring investigation. The hospital did not report any Never Events in the past year.
- The theatre and surgical wards staff we spoke with told us they had access to the electronic incident reporting system, and were clear about incidents that needed to be reported.
- Staff told us learning from incidents took place through weekly and monthly multidisciplinary meetings and bi-monthly audit meetings. In addition, staff on the surgical wards received feedback in weekly briefings, as well as via regular newsletters. Staff were able to describe recent incidents, including those that occurred at other hospital locations within the trust, and they described how learning was shared to aid improvement.
- Divisional managers told us that mandatory training for all staff at senior manager grade and above included a module in investigation of incidents and complaints. However, some staff we spoke with at this level were unaware of this training. We were also told that most trust staff had received training in having difficult conversations, including discussing incidents. Despite asking for evidence that this training had been delivered to all staff, this was not provided by the trust.
- Data provided by the trust showed a better-than-national-average reporting rate of 'no harm'

incidents. Staff also told us they felt confident in the trust's reporting systems, and these elements demonstrated incident reporting systems worked in practice.

- There was a number of serious incidents reported within the surgical division. Between 1 July 2013 and 30 June 2014, 33 serious incidents were reported trust-wide, including seven pressure ulcers graded 3 or 4, four sub-optimal care of the deteriorating patient and three falls. We were told this information was collected and reported on a trust-wide basis and therefore could not identify where in the surgical division these incidents had occurred using the data provided.
- Learning from incidents were fed back to all staff in a variety of ways, including a monthly clinical governance newsletter and via a summary report to divisional leads and the 'safety matters' bulletin.
- Incident investigations and learning focused on human factors; the relationship between human behaviour, system design and safety involved in these cases.
- Staff we spoke with told us they risk-assessed patients who were at risk of developing pressure ulcers, reported incidents when pressure ulcers were detected and were supported by the tissue viability team. It was not clear that the actions recommended from investigations of reported incidents were embedded in the department.
- Although all serious incidents were investigated, we were not assured that there were sufficient proactive initiatives to reduce incidents such as the high numbers of falls. Trials of falls prevention equipment such as alarm mats were being discussed, but had yet to be put into practice.
- Mortality and morbidity meetings were varied in quality and frequency. Meetings took take place at a speciality level, with reporting to the quality and safety committee by exception. We found that some specialties, such as orthopaedics, reviewed mortality and morbidity bi-monthly at the end of the surgeon's audit meetings. Clinical staff told us that some actions and lessons arose from these meetings, but as there were no action plans produced from the meetings, we were unable to determine who was accountable for any actions or learning, or what improvements had occurred as a result of these meetings.

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and harm-free care. This includes information about all new harms, falls with harm, new venous thromboembolism (VTE or blood clots), catheter use with urinary tract infections and new pressure ulcers. Safety Thermometer information was clearly displayed in prominent places on the surgical wards during our inspection.
- On all surgical wards, the trust's performance was better than the England average. Results from the harm-free care report for July 2014 for the cancer, surgery and clinical haematology division, covering all surgical wards at Hammersmith Hospital, showed that scores were close to or over the trust benchmark of 95%. Across all three trust hospital sites, the division was 96% harm-free overall. The investigative sciences and clinical support division, which includes operating theatres and anaesthetics at Hammersmith Hospital, was also reported as over 90% harm-free overall.
- Lead nurses submitted 'nurse-sensitive quality indicators' to the trust's database, which were reviewed by heads of service. We were told these were reported by exception at lead nurse meetings. Most surgical wards were compliant with these indicators at the time of our inspection.

Cleanliness, infection control and hygiene

- We found local and national guidance for infection control was being implemented and followed at the trust.
- The dedicated infection control team for the trust included a senior nurse who specialised in reducing the incidence of surgical site infections. At Hammersmith Hospital, rates were monitored every quarter on the cardiothoracic wards. Overall surgical site infection rates had reduced from 7.7% in Q3 2013/2014 to 1.2% in Q2 2014/2015.
- Following any surgery performed on a patient with a known infection, the theatre was deep cleaned to reduce the risk of cross-infection. These patients were placed at the end of a surgical list, if possible, to further minimise the risk.
- Data gathered prior to the inspection showed there was a low number of catheter acquired urinary tract infections.
- During our observations, and when speaking with patients in surgical wards, we confirmed that all areas were clean and tidy.

- Hand hygiene compliance was audited monthly by staff in each surgical wards. Scores were routinely 95% and above in all areas, and 97.7% across the division. Staff regularly washed their hands and used hand gel between attending to patients. They followed 'bare below the elbow' guidance and were aware of current infection prevention and control guidelines. Gowning procedures were adhered to in the theatre areas and in ward areas staff wore personal protective equipment, such as gloves and aprons, while delivering care.
- The theatre complex at Hammersmith Hospital was clean and equipment stored to enable effective cleaning. There was weekly washing of the walls and stock items were stored in closed cupboards.
- Theatres at Hammersmith Hospital had undergone a programme of renovation to upgrade the ventilation system. The theatres we inspected were clean, safe and well-maintained. Daily and weekly cleaning checklists were displayed in each area and these were complete and up to date. Monthly cleaning audit results showed compliance was over 90% in the preceding 12 months.

Environment and equipment

- The theatre department had started using a barcode system for tracking and tracing surgical equipment to accurately ensure specific surgical sets. We saw this working in practice at Hammersmith Hospital.
- Staff told us there were delays in requesting equipment on some surgical wards and in theatres, which sometimes led to delays in theatres.
- Equipment was serviced by the trust's maintenance team under a planned preventive maintenance schedule. Staff in each theatre team were responsible for checking equipment on a daily basis and any equipment failures or issues were logged as incidents.
- We checked resuscitation equipment, including defibrillators in surgical wards and in theatres, and they were checked daily and were ready for use.
- Some staff at Hammersmith Hospital told us there was no designated emergency operating theatre, which meant there could be delays for patients requiring emergency surgery.
- Staff showed us how they had implemented and continued to use the productive ward programme, designed to reduce waste and improve efficiency and safety on Ward A8.

Medicines

- Medicines were stored safely on most surgical wards. On wards A8 and A9 the medicines room was locked and accessible via a key code. Non-nursing staff had access to this room to access stock supplies. The medicines fridge inside the room was unlocked, but since it as inside a locked room, this was in line with trust policy.
- On the wards and in theatres, medicines were stored correctly in cupboards or fridges where necessary. Fridge temperatures were checked daily to ensure medicines were stored appropriately and safely. Medicines were only prepared when needed, with the exception of medicines for use in emergency cases, which was in line with trust protocol.
- All staff received a competency-based assessment before administering medication. We were told that, when a drug error was identified, staff received another drug competency assessment to ensure patient safety.
- Controlled drugs were checked daily and at night by nursing staff.
- Pharmacists were allocated to each ward to review medicine charts as well as provide patient-specific advice and discharge medication in a timely manner. Processes for nursing staff to order and dispense take-home drugs were in place on surgical wards to expedite patient discharge.

Records

- Patients had their care needs risk-assessed on admission. When their needs changed, these were detailed in the records for all the clinical areas we visited. Patient records showed that staff carried out appropriate checks for consent and medical history prior to starting a procedure.
- Staff on surgical wards described ongoing difficulties they faced since the introduction of an electronic patient administration system in April 2014. Staff spoke of difficulties with information being sent to wrong patients, difficulties in tracking notes and locating test results and letters. The trust had recognised this as a trust-wide issue and implemented a series of actions. Staff told us that this was slowly improving.
- Ward matrons we spoke with told us they did rounds to review patient care, including regular reviews of pressure area documentation. We were not provided with evidence of these rounds.

Surgery

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- In the patient records we reviewed, we found staff sought informed consent from patients which was recorded appropriately and correctly. There was documented evidence of preoperative risk assessments which included establishing informed consent by speaking to pre and post-operative patients about their understanding of their surgery.
- Staff demonstrated knowledge of the Mental Capacity Act 2005 and the implications of this in order to protect patients' rights. Through a review of patient records, we noted that staff had assessed patients' capacity to make decisions; when patients lacked capacity, staff sought advice from professionals and others as appropriate so a decision could be made in the patient's best interest.
- Staff had the appropriate skills and knowledge to seek consent from patients or their representatives. They had received mandatory training in consent and had access to a mobile phone app which could be used to prompt knowledge of the Act and its associated deprivation of liberty safeguards. However, while this was helpful for awareness training, staff told us that more training in dealing with specific cases would be beneficial.
- The trust conducted an annual consent documentation audit against the trust consent policy. Results in October 2013 showed improvements in documentation, including best interest decisions. Although, some areas had dropped below the standard, including documenting of consent for tissue retention and dating of consent by the patient.

Safeguarding

- Systems were in place for staff to report safeguarding concerns. Staff were aware of the process and could explain what was meant by abuse and neglect. This process was supported by staff training and all of the ward staff we spoke with about safeguarding had undertaken safeguarding adults training and safeguarding children's training at level 3.

Mandatory training

- Training records on the wards we visited showed that between 33% and 80% of staff in surgical wards at Hammersmith Hospital had received mandatory training. However, ward matrons told us this data was not always accurate, and felt rates were higher than stated. They told us this was because completion of the online training modules was often not recorded, even if staff had completed this. We were informed the trust had a robust action plan in place to ensure all staff received their mandatory training during the current financial year. Ward matrons told us they were now asking staff to demonstrate completion of each module in person.
- There was a worse-than-average compliance rate with mandatory training among consultant medical staff, and some had not completed any mandatory training. We were not made aware of what was being done to address this low rate of compliance.

Assessing and responding to patient risk

- The surgical wards used a recognised early warning tool called the national early warning score (NEWS), standardising the assessment of acute-illness severity. The trust started using this tool in 2013. We found clear directions for escalation of patients' treatment and staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected.
- Staff described their roles and identified the necessary steps to take in the event of a clinical emergency. They were able to identify the location of emergency equipment and describe the steps outlined in the hospital's emergency policy.
- We were told that the nursing leads attended their allocated wards at 7am every day to ensure that unwell patients had been directed proactively to consultants.
- For preoperative assessments, where patients were seen by the centralised specialist team, we saw that patients were risk-assessed in line with national guidance on preoperative assessment. We could not be assured of the approach to risk management used by the specialties who managed their own preoperative assessment processes. The preoperative checklists for the three patients we reviewed were completed appropriately.

Five steps to safer surgery

- Theatre staff completed safety checks before, during and after surgery and demonstrated a good understanding of the 'Five steps to safer surgery' procedures.
- The trust had started to carry out WHO checklist audits in April 2014, including swab counts. Two secret-shopper-style audits were undertaken against compliance with the WHO surgical safety checklist. The staff we spoke with confirmed there were "observational" audits to verify staff adherence to the

'Five steps to safer surgery' procedures. These highlighted that known allergies and site markings had a low compliance. Results showed 60% compliance with briefing in June and 65% in July 2014. This had been identified on the division's risk register, which stated, "the July 2014 audit showed improvement in some areas on the WHO audit, but the debrief was not occurring regularly enough". The August 2014 audit reviewed at the quality meeting demonstrated improvements in most areas.

- Swab count audits were undertaken monthly since June 2013 on around 20 cases per month across the three hospital sites of the trust. Continued low compliance with handling, labelling of swabs, 'pause for the gauze' (the surgeon stopping while the first cavity count of swabs was being done) and consistency of people counting the swabs had not been addressed.
- Overall, the risk of unsafe surgery was not sufficiently mitigated. Although compliance with the 'five steps' was escalated to the divisional risk register, the actions recommended by the audit did not highlight that there was a very low sample size of cases reviewed, nor did it highlight the very recent introduction of the 'Five steps to safer surgery.' There was, therefore, false assurance for surgical safety.

Nursing staffing

- Surgical wards used an Association of UK University Hospitals approved adult dependency acuity tool to assess the needs for the number of staff on the surgical wards. This assessment was completed every six months. Nursing sensitive indicators of quality, including bed occupancy and level of care, as well as wider measures such as number of incidents, drug errors and complaints, formed part of the tool. The skills mix was reviewed and an increase in staffing could be requested, based on the results of the assessment.
- We found that surgical wards were appropriately and safely staffed throughout this inspection. However, data provided by the trust for Hammersmith Hospital demonstrated worse-than-national-average vacancy rates and use of agency staff. Data showed there was a higher than average use of agency staff on surgical wards at an average of 7%. Ward matrons we spoke with said recruitment drives for nursing staff across the trust had started to reduce reliance on agency staff use.
- In theatres, the July 2014 data showed there was an establishment of 139.63 nursing staff, operating department practitioners and healthcare assistants. There was a 14% vacancy rate among operating department practitioner staff at the hospital and high use of agency staff. We were told that senior managers discussed bank (overtime) and agency use weekly and the number of vacancies in scrub and recovery nursing posts were 'reducing', though anaesthetic support remained a group that was hard to recruit to.
- At the time of the inspection, Ward A8 had a staff establishment for 20 beds, though the ward had a capacity for 26 beds. However, the ward sometimes had to care for more than 20 patients and relied on agency staff to fill these posts. The trust-wide procedure was that extra beds could not be used unless three agency staff were recruited per shift. A business case had been submitted to increase the establishment and recruit four more whole time equivalent registered nurses.
- Rosters showed that staff were being rotated across the trust. In order to maintain the skills mix, staff were usually rotated within specialties in the same division and had to have met certain competencies. We found the skills mix in the surgical division met the Royal College of Nursing (RCN) recommended mix of at least 65% registered nurses to 35% healthcare assistants.
- Nurses in charge, known as ward matrons, were supernumerary and, in line with the RCN guidelines, were not assigned patients to care for when on duty.
- The sickness/absence rate among nursing staff in surgery was 7.67%, which was worse when compared to the national average. However, the rate was stable. Senior nursing staff told us these rates were monitored on a monthly basis but did not confirm whether underlying causes were reviewed.
- Exit interviews were regularly reviewed to obtain feedback from staff. Ward matrons we spoke with told us there were no trends identified from exit interviews as most staff went on to promotions.
- Ward matrons supported requests for healthcare assistants or extra staff to provide one-to-one care when necessary so that patients received appropriate care to meet their needs.
- Some staff told us they felt they needed more nursing staff at night. However, this was not confirmed by the most recent nursing acuity audit which showed that night staffing levels were appropriate to meet the patients' needs.

- A nursing and midwifery staffing escalation guide called 'Care 123' was in place for staff to calculate and review staffing numbers to ensure there were sufficient staff to deliver safe patient care.

Major incident awareness and training

- There was a documented major incident plan which listed key risks that could affect the provision of care and treatment. We were told there was no specific policy for theatres and staff followed trust guidelines.
- There were clear instructions in place for staff to follow in the event of a fire or other major incident. Staff were aware of the plans and described the appropriate actions they would take. We were told there was no specific major incident training for staff but surgical ward staff were aware of the policy.

Are surgery services effective?

Good

Outcomes for patients who had undergone cardiothoracic and hepatobiliary surgery were close to or better than the England average. The trust took part in national and local clinical audits and staff used care pathways effectively. Pain relief was well-managed and the nutritional needs of patients were catered for. Staff were competent to carry out their roles and worked well within multidisciplinary teams. Many procedures and treatments within surgical services across the trust were reviewed against national clinical guidelines.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidelines were managed corporately with a clinical lead assigned to each guideline, whereas national and local audits were managed by the divisions. Some specialties had audited their practice against NICE guidance. For example, staff demonstrated compliance with NICE guidance on management of chronic heart failure in adults (NICE guideline CG108).

Pain relief

- The trust employed a specialist pain team who provided direct support to surgical wards and undertook pain reviews, supported by the outreach team and on-call anaesthetists. Staff we spoke with told us they had access to the dedicated pain team on a daily basis. The pain team worked to evidence-based protocols and had developed local guidelines for patient-controlled analgesia for post-operative and acute pain.
- We observed patients alerting nursing staff to their increased pain and noted they were responded to in a timely manner.
- In April 2014, nurses in the pain service team conducted an audit to assess how pain was managed for patients in medical and surgical areas across the trust's hospital locations who were not normally seen by the team. The audit reported a reduction in the number of patients reporting severe pain. The pain team's lead was undertaking long-term research in reviewing the prevention of chronic pain after thoracic surgery.
- In April 2014, a local audit of pain associated with epidurals concluded that a higher-than-expected number of patients experienced pain when moving and coughing with an epidural infusion. Recommendations to improve practice were identified, such as training for ward-based staff, and we were told this subject would be re-audited in 2015.

Nutrition and hydration

- Patient records included an assessment of their nutritional requirements. Patients who were able to eat and drink normally told us they were given a choice of food and drink.
- Where patients had a poor nutritional intake, they were risk-assessed and fluid and nutrition charts were in place to help ensure they received adequate food and drink. Where necessary, an assessment was undertaken by a dietician and specific interventions recommended.
- Patient records we reviewed showed that risks of nausea and vomiting post-operatively were assessed and discussed with patients at the pre-assessment stage.

Patient outcomes

- Performance in some national audits demonstrated that outcomes for patients were within or better than the England average, particularly for major trauma and vascular surgery.
- Hammersmith's Hospital Standardised Mortality Ratio (HSMR), which compares the expected rate of death in a hospital with the actual rate of death, was statistically significantly low and better than the national average.

Surgery

- Liver and pancreatic cancer audits were monitored by the local cancer network area that Hammersmith Hospital served (North West London). Survival rates were better than the England average.
- Cardiac care outcome data showed that the trust performed close to or slightly better than the England average.
- There was a trust-wide lead for delivering the enhanced recovery programme. Surgical ward staff told us all patients were considered for the enhanced recovery programme if suitable. However, the trust was unable to tell us how many patients commenced on this programme.

Competent staff

- Junior doctors we spoke with told us they were not asked to perform procedures unsupervised that they did not feel competent to do.
- The trust funded a number of leadership programmes for staff, although we were not provided with detailed information showing how many staff within the surgical areas and in theatres had undertaken these programmes.
- Non-medical staff we spoke with told us they received regular one-to-one supervision with their manager, while nursing staff also received regular feedback from an assigned mentor.
- Ward matrons monitored staff compliance with the trust's mandatory training programme. Attendance rates were slightly lower than the trust's expected standard of 90%, but we were told this was hard to monitor as some training modules were face-to-face and others were via e-learning. Some ward matrons had to watch staff members completing these modules in order to evidence that they had been completed.
- A number of staff had attended specialist courses and masters programmes. All theatre nursing and operating department practitioner staff were expected to complete a theatre orientation and perioperative handbook. Records were not available to confirm the proportion of staff that had attended this training. As of July 2014, 70% of nursing staff, operating department practitioners and healthcare assistants had completed their mandatory training.
- Staff told us they were regularly provided with opportunities for further study and training, and were able to attend courses as needed.
- Anaesthetic outcomes were being monitored against the Royal College of Anaesthetists guidelines and results were available to consultants. These were being utilised in appraisals and revalidations.

Multidisciplinary working

- Trainee doctors, nurses, physiotherapists and pharmacists we spoke with told us they were well-supported. Allied healthcare professionals worked well with ward-based staff to support patients' recovery and their timely and safe discharge following surgery.
- Multidisciplinary team meetings were well-established to support the planning and delivery of patient-centred care. These daily meetings involved nursing staff, therapists, medical staff, social workers and safeguarding leads. The meeting ensured that patients' needs were fully explored and, where necessary, actions put in place to better meet them.

Seven-day services

- Consultants told us that they undertook ward rounds seven days a week. On Saturdays and Sundays they reviewed only new patients. The consultants were on site from 8am to 5pm Monday to Friday and an on-call system operated out of hours and at weekends.
- Physiotherapy services were provided to patients on surgical wards at the hospital seven days a week. Occupational therapy, speech and language therapy and dietetics were available 8am to 5pm Monday to Friday only.
- Staff told us out-of-hours imaging and pharmacy support was available when required. The imaging directorate was available Monday to Friday, 9am to 5pm, with extended hours and weekends for magnetic resonance imaging (MRI), ultrasound and x-rays.
- Out-of-hours emergency services ran seven days per week and offered ad hoc sessions to address particular backlogs or peaks in demand.

Are surgery services caring?

Good

Feedback from patients and their relatives was positive overall. Staff interacted well with patients and did their best

to make them comfortable. Staff demonstrated a caring approach and the NHS Friends and Family Test scores were better than the national average for almost all surgical wards.

Procedures were in place to gain informed consent and involve patients at every stage. Patients' privacy and dignity were respected.

Compassionate care

- The hospital's NHS Friends and Family Test results were better than the national average. Surgical ward matrons we spoke with had received an analysis of the responses and told us they were not aware of any trends.
- Patients we spoke with were positive about the care received. Throughout our inspection we saw that staff were caring and compassionate to patients.
- Patients' privacy and dignity were respected, and male and female patients, because they were often wearing theatre gowns, had separate waiting areas in the theatre reception.

Patient understanding and involvement

- Patients were allocated a named nurse to ensure continuity of care.
- We observed positive interactions between staff and patients and their relatives when seeking verbal consent. The patients we spoke with confirmed that their consent had been sought prior to care and treatment being delivered.
- Patients and their families were involved in, and were central to, decision-making about their care and support. They had been given the opportunity to speak with the consultant looking after them.
- We found relatives and/or the patient's representatives were also consulted in discussions about the discharge planning process.
- Patients' main carers were given the option of having an 'I am a carer' card to identify them to staff so they could be allowed visits to their loved ones outside of visiting hours.

Emotional support

- Staff understood the importance of providing patients with emotional support. We observed positive interactions between staff and patients and saw staff providing reassurance and comfort to people who were anxious or worried.

Are surgery services responsive?

Requires improvement

The surgical department had a significant backlog of patients who were awaiting elective surgery, however the trust did provide us with overarching plans to reduce this backlog. There was insufficient capacity to ensure that patients admitted to the surgical services could be seen promptly. The clinical impact of cancellations and delays in surgery was not monitored in a consistent and robust manner. Staff told us that patients were frequently cared for in inappropriate areas, such as in theatre overnight.

However, the care in theatres was satisfactory. The surgical admissions lounge was a suitable environment and provided patients with comfort, dignity and confidentiality.

Service planning and delivery to meet the needs of local people

- There was 24-hour cover for emergency operations. All theatres were available over the weekend and at night for emergency surgery.

Access and flow

- Referral to treatment times varied over the last year and were close to the national average of 18 weeks. (Operational standards say that 90% of admitted patients should start consultant-led treatment within 18 weeks of referral.)
- Theatre use was slightly below the trust's target of 85%, and we were not provided with an explanation for this.
- Bed occupancy averaged over 90% on a number of surgical wards in the preceding 12 months. Staff told us there were daily difficulties in identifying an appropriate bed for patients.
- Patients undergoing cardiac surgery were put on an enhanced recovery programme from pre-assessment.
- There was a high rate of patients who did not show up for their surgery appointment. We were told that patients were telephoned prior to the date of surgery to remind them, but this initiative had only started in late August 2014 and therefore we were unable to assess its impact at the time of our inspection.

Surgery

- Cancellation rates for surgical procedures were worse than the national average, averaging 15%. We were not made aware of the actions being taken to address this higher-than-average rate. However, staff told us that cancellations were infrequent in day surgery.
- The trust reported that more than 180 patients were cared for in non-surgical wards due to a lack of surgical beds in the last year. We could not be assured that staff in these non-surgical areas had the appropriate skills and competencies to provide care to surgical patients.
- Staff told us that patients sometimes experienced long delays in the recovery area after their surgery due to a lack of beds on the wards. Delays in transferring patients back to the wards from recovery were an identified risk and were documented on the divisional and trust's risk registers.
- Pre-assessment had been identified by the divisional management team as an area of weakness. To address this issue, preoperative assessment was being gradually centralised to reduce the number of patients who did not attend or who cancelled their appointment. Around 40% of preoperative assessments were undertaken at divisional level, whereas others were undertaken at specialty level. Pre-assessment was recognised by the trust as a risk and as a contributing factor in the high rates of non-attending patients and the higher-than-average referral to treatment times.
- The increase in the backlog of patients who had been waiting more than 18 weeks represented a major performance issue which was documented on the risk register. A progress report to address this issue indicated that the backlog had stabilised in the period March to August 2014. However, managers were unable to provide us with assurances and articulate the actions they were taking to manage this backlog in line with trust-wide plans.

Discharge planning

- Between April and July 2014, there were 4,000 trust-wide electronic discharge summaries awaiting clinical input. The trust was not able to show us how many of these were attributable to surgical wards, so we were unable to ascertain if this meant GPs were not receiving important clinical information about patient admissions.
- Nurses and doctors told us there were no delays to discharging patients at the weekend.

Meeting people's individual needs

- We saw that all the dementia patients had a food chart and were given assistance at meal times to ensure their dietary needs were met. Fluid intake was also monitored most of the time, although we noted some inconsistencies in the quality of the records.
- The trust had 'dementia champions' who were available to provide support and guidance for both patients and staff. A 'butterfly scheme' for patients living with dementia was used in the ward areas. The scheme gave staff information about patients' likes, dislikes and choices and helped staff manage care of patients with dementia in a sensitive and person-centred way.
- The hospital had clinical and support staff who also acted as translators and were able to offer instant access for language support to patients.
- Arrangements were made to ensure that patients were treated in single-sex areas throughout the wards and theatres.
- A noticeboard outlined the various multi-faith services available with timings for specific prayers and services. Patients also had access to one-to-one support from the chaplaincy service.

Learning from complaints and concerns

- We saw information leaflets and posters about the Patient Advice and Liaison Service (PALS) and information about how to make complaints displayed near the nurses' station in most surgical ward areas. However, ward staff told us they received no formal training in complaints investigation.
- We noted there had been a monthly increase in complaints when comparing year-on-year between quarter one (April to July) 2013 and 2014 in the division of surgery, cancer and cardiovascular sciences. In quarter one of 2013, the complaints trends on surgical wards were: poor clinical care; poor nursing care; appointments; delays and cancellations; and ineffective treatment and admission; discharge; and transfer arrangements. In quarter one of 2014, the trends were: poor clinical care; poor nursing care; ineffective treatment and appointments; delays/cancellations; and problems with communication/information for patients (written and oral). There was also an increase in complaints about appointment delays and cancellations from 6% to 12%.
- Nursing staff regularly shared complaints, concerns and compliments with staff on a monthly basis.

Surgery

Are surgery services well-led?

Requires improvement

The inability of managers to provide us with assurances of the actions they were taking to manage the backlog of patients awaiting surgical procedures and the failure to ensure the 'Five steps to safer surgery' was embedded in practice impacted negatively on the service being well-led.

However, the trust had a clinically-led vision for surgical services at Hammersmith Hospital and most staff were aware of this. There was an open and accessible culture that created positive teamwork among staff.

There were governance arrangements for auditing and monitoring services. Senior staff created opportunities to proactively engage with staff and the public. Long-term plans for services at Hammersmith Hospital had been articulated, discussed with staff in open forums and agreed with relevant stakeholders.

Vision and strategy for this service

- There were plans to make Hammersmith Hospital the main hub for a range of specialties, including renal, haematology, cancer and cardiology and some elective neurosurgery. The trust had a clinically-led vision for surgical services at the hospital and most staff we spoke with were aware of this.
- Divisional management staff told us that the strategic direction had been agreed with the local clinical commissioning groups and other stakeholders.

Governance, risk management and quality measurement

- The trust had restructured its governance arrangements within the last year and this meant surgical ward areas were managed within the division of surgery, cancer and cardiovascular sciences, while pre-assessment and theatres were now in the investigative sciences and clinical support division.
- All specialty areas maintained their own risk register and risks deemed to be the most significant were escalated to the trust's overall risk register. Ward matrons were encouraged to identify and escalate risks to the trust's risk register as appropriate.
- There were identified clinical governance leads at divisional level, with the heads of service being accountable for clinical governance within their areas.
- There were bi-monthly governance half days, known as audit days, on the wards and in theatres. Discussions at open days encouraged contributions from staff, and included the 'Five steps to safer surgery' checklist, recently reported incidents, complaints and overall theatre performance.
- Surgical wards held monthly clinical governance meetings at which incidents, risks, audits and adherence to guidance were discussed.
- Divisional management teams told us the medical director discussed serious and moderate incidents every Friday with senior management. However, these meetings were not minuted so we could not verify what actions were taken following these discussions.
- Lead nurses collated the monthly harm-free care report which identified nursing quality indicators, including measures such pressure ulcers, falls, hospital-acquired catheter urinary tract infections, complaints and compliance with intentional rounding (or comfort rounds). Each ward was benchmarked and results were reported to the board on a monthly basis.
- Cost improvement plans were risk-assessed by the clinical team and reviewed at the quality committee before being agreed to ensure that patient safety implications were considered.
- The July 2014 divisional complaints report stated that complaint themes were not reviewed alongside incidents. Therefore, it was not clear how integrated this system was.

Leadership of service

- The leads for each clinical service area, or chief clinician, worked across the three hospital locations of the trust.
- There was a strong leadership culture within nursing. Senior nursing staff and ward matrons led by example and demonstrated their personal accountability for the service and their staff. However, some staff we spoke with on the surgical wards at Hammersmith Hospital told us that the director of nursing had not yet visited their ward areas.

Culture within the service

- Staff spoke of an open and candid culture in which problems and emerging concerns were escalated to

senior management without hesitation. Ward staff told us senior staff were open and created a positive teamwork culture, with ward managers visited weekly by their managers.

- There were no whistleblowing cases open at the time of the inspection but staff we spoke with were aware of the trust's whistleblowing policy.
- Junior and trainee surgical medical staff, who had started their rotations three weeks before we inspected the trust, told us they felt well-supported by consultants. Following feedback from medical trainees in the 2013 General Medical Council trainee report, we were told changes were made to improve patient and trainee experience. Foundation year 2 doctors were withdrawn from cardiac surgery in 2013 and advanced nurse practitioners were recruited.

Public and staff engagement

- There were weekly consultation meetings with staff over a two-month period in 2014 regarding the clinical strategy for the hospital.
- The clinical health psychology department led a number of interventions to support staff, including Schwartz rounds (sessions for staff from all disciplines to discuss difficult emotional and social issues arising from patient care), mindfulness for staff and patients and reflective practice for clinical nurse specialists.
- There were patient and people 'prescription' for staff to highlight good achievements with nursing sensitive indicators on surgical wards. Feedback was provided to nursing staff to acknowledge good performance in harm-free care.
- Ward staff in surgical areas spoke about regular team-building events which were positive to develop team working.
- Results from the real-time patient feedback system, 'I track', were monitored and results were fed back to ward staff.

Critical care

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

Information about the service

Hammersmith Hospital has a general intensive care unit (ICU), a cardiothoracic critical care unit (CTCCU), a coronary care unit (CCU) and renal high dependency unit (HDU). The ICU admitted 550 patients in 2013 with 5,500 bed days, and this has been increasing against previous years. We inspected each unit.

We spoke with 35 members of staff, including nurses, doctors, administration/clerical personnel, allied healthcare professionals and managerial staff. We also spoke with 10 patients, family and friends, checked 12 records and 10 pieces of equipment.

Summary of findings

Critical care services at Hammersmith Hospital had issues with both bed capacity and staffing arrangements. Capacity was stretched and staffing levels were either not appropriate or not taking into account other arrangements in the hospital. Some aspects of safety requirements were not always adhered to. However, there was good patient feedback and good outcomes for patients. There was mostly a teamwork ethic but some tensions between staff on the ICU existed.

Critical care

Are critical care services safe?

Requires improvement

The safety culture was variable across the units. Items were not always clean and checks for cleanliness were not always carried out. Nursing and medical staffing levels were stretched on some units and not always in line with national guidance. Safety checks were not always completed and mandatory training was not up to date.

Incidents

- Staff were aware of how to report incidents and showed us the electronic system they used to report them.
- Staff were able to tell us about the trustwide learning as a result of 'Never Events' that impacted on all sites. For example, the learning from one 'Never Event' on another site resulted in new trust wide guidance for nasogastric tubes (NG tubes). Monthly meetings took place in the ICU to review incidents and identify trends. However, when we reviewed the latest incident reports, they showed the main actions being taken were reminding staff about policies rather than changes to procedure or training.
- There had been a serious incident of an unexpected death in the ICU, but this was still being investigated at the time of our inspection. There were 60 incidents in the critical care/anaesthetics/pain department across the trust, with most of them related to medicine errors, implementation of care, pressure ulcers or equipment.
- Mortality and morbidity meetings took place every two months in each unit which all grades of staff on the units attended. These not only included a discussion on learning from deaths but also audits that related to mortality such as cardiac arrests. Minutes showed staff were able to openly discuss any learning and improvements that could be made.

Safety thermometer

- Trust harm free care information was displayed and variable between the units. The CTCCU had recorded only three pressure ulcers and one fall since April 2014. Completion of assessments for falls, cannulas and pressure ulcers was 100% and 90% for catheters and pain scores. However venous thromboembolism (VTE or blood clots) screening was low at below 85% every week in the last three months, with some weeks scoring 0 and 50%. Visual infusion phlebitis assessment completion (for checking early signs of phlebitis) was also low at 70%.
- There had been a recent pressure ulcer in the ICU and a total of 7 in 2014; two grade 3–4. There were no reported patient falls. The completion rate for assessments for pressure ulcers was 96% but falls and catheters was 67%, pain scores was 89%, and cannulas was 75%. Overall harm-free care was 84.6%.
- In the renal HDU, the last pressure ulcer was in July 2014 and the last fall was in April 2014. Completion of assessments was 100% for pressure ulcers, catheters, nutrition, central venous catheter (CVC) and pain scores, but MRSA screening was 77%. Harm-free care was 91.1%
- A weekly ward round included tissue viability nurses, and staff were assessed for their competency to treat and prevent patients developing pressure ulcers.

Cleanliness, infection control and hygiene

- Infection control was not always appropriate in the ICU. We observed one member of staff make contact with a neutropenic patient (a patient with an abnormally low count of white blood cells) without any personal protective equipment such as gloves or an apron, despite CQC staff being told to ensure they wore protective equipment if they were to make contact with the patient. There was one MRSA, one Clostridium difficile (C. difficile) and two neutropenic patients in the ICU when we inspected. There were four patients identified as having C. difficile to date in 2014. However, all affected patients had input from microbiology and investigations were ongoing. The last cleaning audit reported 98.8% compliance but hand hygiene compliance was 85%. A CVC action plan was in place to reduce blood infections and there was a trust-wide action plan to reduce C. difficile.
- There had been one case of C. difficile on the CTCCU since April 2014 but no MRSA since the matron had started there over a year ago. Their last cleaning audit showed 98.5% compliance and 100% hand hygiene compliance. We observed this ward to be clean and tidy. MRSA and CVC screening was 100%.
- The last case of C. difficile on the renal HDU was July 2014 and there had been two cases so far in 2014. Hand hygiene compliance was 100% and the last cleaning audit scored 98.7%. There had been no incidents of patients acquiring MRSA so far in 2014.

- Isolation side rooms with appropriate signage were available in the CTCCU and ICU and these were being used appropriately for patients with infections.
- Sharps and medical waste bins were labelled and used appropriately.

Environment and equipment

- Most equipment was clean with stickers attached to show that it had been cleaned within 24 hours prior to our inspection. Service checks were regularly undertaken. However, despite up-to-date labelling, some unit's equipment was still dirty, such as an ultrasound machine and a dialysis machine. These were later cleaned when we reported it. Cleaning checks in the CTCCU had only been done twice in the week prior to our inspection. One utility cupboard was not lockable and one continuous positive airway pressure (CPAP) machine had not been serviced since 2013.
- Physiotherapists told us there was a lack of equipment such as hoists and patient chairs to use inpatient rehabilitation on the ICU. Hoists reportedly took up to four weeks to repair. There was also a lack CPAP machines in the renal HDU. However, staff were trained in operating the machines in their respective units.
- We noted that the environment was appropriate for treating critically ill patients, with ample space around bed areas.

Medicines

- Most medicines were appropriately stored and recorded with drug charts fully completed, including details of any patients' allergies. However, some medicines were stored in cupboards that only had keypad access. Only some staff knew the code for these cupboards, which they told us they sometimes forgot. In addition, we found some controlled drugs stored in a drawer that was not locked. This was not in line with the regulations on the management of controlled drugs.

Records

- Review of patient records showed that all but two were complete and up to date. Records completed for patients included urinary catheter and peripheral cannula insertion records, tracheostomy daily checks, NG tube position charts, observation charts, wound assessments, continence care records, VTE assessments and turning charts.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their responsibilities under the Mental Capacity Act 2005 including when to make a best-interest assessment. However, one patient had the bed rail up on one side of their bed and this had not been assessed as in the patient's best interest. Staff lowered the rail when we reported it.

Safeguarding

- Staff were aware of their responsibility to safeguard vulnerable adults and how to report concerns, including to the safeguarding leads for the trust.

Mandatory training

- Staff reported that they kept up to date with mandatory training. However, the renal HDU reported an overall mandatory training rate of around 75%. Staff said they did not feel this was a fair reflection due to issues with recording attendance.
- Staff attendance at intermediate life support training was 79% in the HDUs and 76% in the ICU. Despite this, some staff expressed concerns there was not enough availability of the course.
- Aseptic non-touch technique training on the CTCCU was mainly over 95% for nurses and over 85% for doctors. Overall, staff attendance of mandatory training on the CTCCU was 73% and 78% for critical care.
- Mandatory training records for the medical HDU showed that training included induction, patient-handling skills, venepuncture/cannulation, financial management, safeguarding, policies and procedures and interview skills.
- Staff reported receiving appropriate comprehensive inductions for their units, including an orientation, corporate induction, policies and protocols.

Assessing and responding to patient risk

- The national early warning score (NEWS) system was in use on the units and deteriorating patients were appropriately responded to by, for example, carrying out additional observations and calling in medical or critical care support.

Nursing staffing

- Although some staff in ICU reported low staffing levels, we noted nursing staffing levels to be appropriate in the ICU and CTCCU with one-to-one or one-to-two nursing ratios, depending on patients' acuity level. This was corroborated to be a consistent pattern when we

checked the duty rota. However, patients in the renal HDU were sometimes cared for at a ratio of 1 to 2.5 with two nurses covering five critical care patients and six nurses covering whole units, 22 beds of which were level 0 and 1 patients. Nursing staff said this ratio had been worked out using an acuity tool; however, staff reported that they felt "stretched". We were told that some shifts were left unfilled if staff were absent due to illness.

- Senior nurses were not part of the shift figures as recommended nationally and the ICU had a supernumerary nurse band 7.
- There was only one site practitioner at Hammersmith Hospital out of hours covering medical emergencies.
- The nurse vacancy rates were high but had recently decreased. This was still 17% in the ICU and 14% in the CTCCU, although it was 10% overall in critical care. Nonetheless, there was a high use of bank (overtime) and agency staff at over 30% in the ICU but only 3.7% in the CTCCU. Agency/bank staff were partly used so new recruits could initially remain supernumerary. Around a third of bank/agency staff were used frequently by critical care and so were familiar with the policies and processes of the units. Staff were also able to be redistributed between the sites as staff contracts covered all of the trust and ensured staff were inducted to be familiar with each critical care unit.

Medical staffing

- Medical staffing levels were mostly appropriate with a consultant, a registrar and three junior doctors covering 13 ICU patients during the day shift and a total of five consultants on a weekly rotation to ensure continuity of care. This meant the consultant ratio was 1:13 which met national guidance. There was at least a registrar and junior doctor on site out of hours who were airway trained with an on-call consultant. However, due to a lack of an outreach service, ICU staff were called if there was a patient who had an airway issue. Although medical staff felt this did not affect patient outcomes, they agreed this sometimes caused workload pressures. They said they would welcome some form of team to deal with patients with high NEWS scores, whether it was an outreach service or critical care, multidisciplinary team patient at risk.
- Medical staff on the ICU had no clinic or theatre list commitments in the hospital, although CTCCU consultants did at times.
- The CTCCU mainly cared for level 2 patients and had one consultant, one registrar and two junior doctors who were critical care and airway trained. There was also at least a registrar and an anaesthetist available who were on call overnight and were airway trained. Despite being governed by critical care, CTCCU patients were seen by their cardiac surgeons up to two times a day. A ward round took place daily with an afternoon handover.
- A medical registrar was always on duty on the renal HDU but they had to call ICU staff if they required airway-trained staff.

Are critical care services effective?

Not sufficient evidence to rate

There were several fundamental audit results that were not supplied to us; the lack of which meant that the hospital could not demonstrate that its critical care services were effective. However, the service had competent staff and patients had multidisciplinary team input into their care.

Evidence-based care and treatment

- Critical care services followed most National Institute for Health and Care Excellence (NICE) and other national guidance. However, NICE guideline CG83 (rehabilitation after critical illness) was not followed as there was a lack of physiotherapy staff to give the recommended rehabilitation time to patients. There were only two physiotherapists when there should be three and they were only able to rehabilitate around six to seven patients a day in the ICU for the appropriate amount of time.
- Diabetes screening and referrals were in place.
- 95% of ICU patients were discharged within NICE guidance.

Pain relief

- Patients told us their pain was well-controlled in a timely manner by staff.

Nutrition and hydration

- Patients were happy with the food and fluids they received and said they were given choices. They said water was always available to drink if they needed it.

Critical care

Patient outcomes

- The hospital had recently joined ICNARC in April 2014. Before this, they were benchmarking themselves to the North West London collaboration of ICUs.
- The trust submission of its own data reported figures from the critical care network for April to June 2014. These results showed the unit had a better (or lower) mortality rate than comparator units and better (lower) rates of unplanned re-admissions.
- The unit had historically been benchmarking its outcomes through the North West London collaboration of ICUs. These results showed an overall compliance of 90%. Concerns with late-night discharges and lack of a patient satisfaction survey were highlighted. The competencies audit had been non-compliant since last year. However, previous concerns from this audit had been resolved, including bed capacity, ventilator care bundles and clinical governance.
- The critical care service had participated in a number of audits, including National Confidential Enquiry into Patient Outcome and Death (NCEPOD), sepsis, severe acute respiratory failure and infection, stress ulcer prophylaxis, tracheostomy, cardiac arrests and potential donor cardiac arrests. Although we did not receive the results of most of these, the actions taken included establishing a critical care group, increasing bed numbers, more communication between bed managers and units, change of antibiotics for hypothermia patients and reviews of clinical guidelines and policies. The potential donor audit showed a low referral rate to a donor nurse.

Competent staff

- Staff were competent to care for the patients they treated, including senior staff being trained in advanced life support. New staff were kept supernumerary until they were competent to fulfil their roles. Nursing staff in the CTCCU had cardiac training, while those in the renal HDU had undertaken renal courses.
- Medical staff were airway trained in the ICU and CTCCU.
- Staff had annual appraisals on their performance and were on agreed career paths. One nurse told us they were on a leadership pathway with competency training and deputising their team leader when they were away.

Multidisciplinary working

- Physiotherapists were unable to take part in ward rounds on the ICU due to a lack of staff. Otherwise there was good multidisciplinary working with crash team (who stand by to resuscitate patients), with physiotherapy input on the HDU and physiotherapy input and microbiology on the ICU when they could. The CTCCU had speech and language therapy, physiotherapy and occupational therapy input. All critical care services had a dedicated pharmacist.

Seven-day services

- There was a junior doctor and registrar available out of hours on the ICU. A physiotherapist was also on call at night.
- Out-of-hours imaging was available with an on-call consultant.

Are critical care services caring?

Good

Patients gave mostly positive feedback regarding critical care services, with good reports about privacy, dignity and involvement in their care. Patients were given emotional support if they wanted it, but some staff on the ICU were not aware of the emotional support that could be offered to patients.

Compassionate care

- We observed compassionate care delivered by all members of staff and patients were treated with privacy and dignity.
- Most patients told us they had a good patient experience. One patient stated, "[I] cannot fault the staff", and another said, "[the] renal unit is like a family". Some patients said that occasionally members of staff had a poor attitude. However, most patients said they could get a nurse to support them when they needed.
- The CTCCU used a real-time tracking system called 'I track' to get patient feedback on a weekly basis and this was mainly positive. Since April 2014, scores of over 90% were reported for most weeks for each patient experience question such as 'being treated with dignity and respect'. However, the hospital's NHS Friends and Family Test scores were mixed, with some weeks scoring over 90 but four weeks scoring under 70. However, the overall score for the unit since April 2014 was 80, which was above the national average.
- The latest family and friends satisfaction survey for the ICU was from June 2013. This showed 80% of patients' family and friends were happy with their care. However,

there were concerns about the length of visiting times and information from staff. An action plan was in place to extend visiting hours as well as highlight the results to staff.
- The renal HDU had a feedback tracking system called 'I care' which showed patient feedback as positive, particularly for privacy and dignity.

Patient understanding and involvement

- Most patients were happy with their involvement in their care and said staff explained everything in a way they could understand. The latest patient satisfaction survey for the ICU showed people felt involved in their care and we observed staff explaining care to patients, family and their friends in a clear way.

Emotional support

- Patients were given emotional support if they wanted it, including during organ donation discussions. However, some staff on the ICU were not aware of the emotional support that could be offered to patients.

Are critical care services responsive?

Requires improvement

There was a lack of capacity in critical care, meaning that admissions and transfers to the units were often delayed and patients were sometimes cared for in inappropriate areas. The service was not always responsive to patients' needs such as providing information or allowing visits from friends and relatives to be flexible.

Service planning and delivery to meet the needs of local people

- There was a lack of physical space in the CTCCU which meant some equipment was stored in corridors.
- Due to the amount of renal patients seen at the hospital, dialysis machines were available in the ICU and we saw these in use.
- There had been an increase in the acuity of patients in recent months with patients requiring five organ support and more requiring four organ support.
- Accommodation was made available for family and friends if necessary.

Access and flow

- The CCU critical care beds were full on the day we inspected, although the unit had an average length of stay of one day. We were told that patients were waiting to be admitted but had to stay in the catheterisation laboratory due to the lack of beds.
- Senior staff in the renal HDU confirmed that there were delayed admissions. We were told the renal HDU frequently had outliers and that patient swaps with other units took time.
- Conference calls took place twice daily to address bed management and capacity in critical care.
- Bed occupation on the CTCCU was within acceptable levels at 79% in the last three months and with a two-day length of stay. However, bed occupation in all other areas was high.
- Bed occupation in the ICU was over 95% on the staffed 14 beds, whereas it was just below 85% for all 16 beds. Research has suggested that care can become compromised at occupancy levels of 85% and above. The ICU had 13 patients when we inspected, with 14 beds staff-funded and 16 beds available overall. There were 10 level 3 and four level 2 beds. In the last month, although sometimes there were two beds available in the ICU, there were often none after 1pm and there were never any beds available in the HDUs. This was reflected in the critical care performance figures as the ICU had 5% of patient admission delayed by more than two hours in the last year (40 patients) with delays averaging five hours. Twenty-two elective surgeries were cancelled since April 2013, with an average length of stay of 6.4 days and 32% of discharges delayed in 2014/15. However, there was only one non-clinical transfer in 2014/15, 5% of patients (12) were readmitted within 48 hours and 4% of transfers (23 patients) were out of hours.
- The renal HDU had a bed occupancy rate of 93% in the last three months. Staff on the ICU reported difficulties in transferring patients to the CCU and renal HDU due to a lack of beds. This meant that out-of-hours discharges sometimes took place and the anaesthetist's room in theatres was sometimes used for level 2 patients. To improve the situation, management had agreed to a new general surgical and/or medical HDU and would fund staff for the additional ICU beds that were available to ensure they could be appropriately staffed.
- Follow-up clinics run by a consultant took place for patients who were transferred from the ICU. This

occurred monthly and was open to any patient who stayed in the ICU over four days. While nurses sometimes attended, there was no formal nurse input into these clinics.
- Admission criteria was in place for the CTCCU to ensure it only cared for level 2 and 3 patients but also identified when patients should have ICU support.

Meeting people's individual needs

- Information leaflets were available such as on MRSA screening and C. difficile but we saw no other information leaflets.
- Translation services were available for people who spoke limited or no English.
- A dementia care record approved by the Alzheimer's Society and Royal College of Nursing was in place which included the person's photo, interests, and routines. Dementia assessments also took place and staff were aware of when to complete these. Staff were also aware of when to refer people to the learning disability team.
- Visiting times were displayed in all the units, but patients, family and friends felt the times were inflexible.
- A quiet room for family and friends was available and there were also separate toilets and showers for male and female patients. Side rooms were also available in the cardiothoracic ward for level 1 patients so that there would be no breach of same-sex accommodation.

Learning from complaints and concerns

- There was a good complaints learning ethos in the CTCCU and HDUs. However, no complaints or Patient Advice and Liaison Service (PALS) information were displayed and some patients reported not knowing how to make a formal complaint. Nevertheless, a response to a patient focus group resulted in ear plugs and eye shields being made available to patients following complaints about noise and bright light.

Are critical care services well-led?

Requires improvement

The lack of bed capacity had been on the risk register since 2008 and there was no completion date for resolving this. Leadership was visible and responsive, except at divisional level. There were different governance arrangements for the CTCCU, ICU and the HDUs. However, they offered appropriate support and monitored performance. There was some staff engagement but staff were not always aware of the strategy for their respective clinical areas.

Vision and strategy for this service

- The vision and strategy for the service was to plan for the downgrading of Charing Cross Hospital and expand the critical care units of both Hammersmith and St Mary's Hospitals. In particular, there was a plan to add HDU capacity at Hammersmith Hospital for patients after ear, nose and throat, urology and head and neck surgery, as well as to ensure that IntelliVue Clinical Information Portfolio (ICIP) was available. ICIP is an information system used by clinicians to chart and manage patient care in intensive care, operating rooms, and obstetrics units.
- There was a lack of awareness of the service's vision and strategy from some non-senior staff. Some staff were only able to say there was a plan for recruitment.

Governance, risk management and quality measurement

- There were governance arrangements in critical care over the CTCCU and the ICU but not the two HDUs, which were governed by the medicine directorate.
- The CTCCU is governed by cardiothoracics and is part of the surgical division. However, staff we spoke with were unclear about the governance arrangements and thought CTCCU was governed by critical care and had been combined into one unit. They stated this arrangement was far better, especially considering the support they required for patients.
- A new critical care group had been set up and this was welcomed by staff at all levels.
- The critical care service had an up-to-date risk register which included the lack of an outreach service at the hospital and this situation was to be reviewed. Other risks included a lack of trainee doctors and a lack of critical care beds. However, the lack of beds had been on the risk register since 2008 and there was no completion date for resolving this.
- Monthly divisional quality and safety meetings took place across the units which reviewed incidents and identified themes. They also reviewed patient feedback, mortality and performance.
- The service had recently started submitting information to ICNARC and had been monitoring its performance via the critical care network.

- The renal HDU had staff from the Royal Free London NHS Foundation Trust peer review their performance. A report on this review had not been received at the time of inspection.

Leadership of service

- Staff praised the local leadership, particularly the general manager, but felt there were some blocks on requests from senior divisional staff. Staff felt the leadership was visible other than at divisional level. They said the executive team had been very responsive, including the chief executive, in dealing immediately with an issue regarding junior doctor induction when it was raised.
- There were no band 8 physiotherapists at this hospital. Therefore, while there was managerial support for physiotherapists, there was a lack of clinical support.

Culture within the service

- There was a low staff turnover rate among most staff groups, apart from physiotherapy.
- Staff were happy with the teamwork in the units and across sites, with staff commenting they were supported by their colleagues.
- The CTCCU staff said the team was cohesive and worked collaboratively. Staff felt empowered to challenge others.
- Senior staff reported a better relationship with the trust's leadership team since the new chief executive had arrived, and they felt this had improved staff morale.
- Critical care staff had been nominated for a trust award for outstanding care.
- Sickness rates were 4% in the cardiothoracic unit and 5.8% in the ICU which were around or above the national average.

Public and staff engagement

- Most staff felt engaged with the trust and the critical care services, apart from the staff in the ICU. However, ICU nurses did report being involved in audits such as catheter and cannula care. Staff suggestion boxes were also available.
- Monthly unit meetings took place in the ICU to discuss the service's performance.
- A patient, family and friends focus group for the ICU took place every three months which enabled an open discussions about what the ICU was doing well and what could be improved.
- There was no feedback or suggestion box in the ICU.
- A newsletter called In the Loop was produced to highlight recent incidents and changes to guidance.

Innovation, improvement and sustainability

- The critical care service took part in a number of research projects and audits. The CTCCU were involved in a transfusion indication threshold reduction study. The renal HDU was involved in research on immune-suppressants.
- There was collaborative working with other organisations on research projects.

Services for children and young people

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

Information about the service

The David Harvey children's ambulatory care unit provides an open access, walk-in service between the hours of 9am and 5pm Monday to Friday to children and young people. The department was established in 2001 and has a total of nine beds which are used for the assessment and stabilisation of children who present to the unit. Children requiring in-patient treatment are transferred to alternative hospitals such as St Mary's Hospital in Paddington. The service is supported by children's nurses, consultant paediatricians, play specialists and externally commissioned GPs. In addition, the department has a children's outpatient department which hosts a range of specialist children's clinics ranging from, but not limited to, cardiology, neurology, surgery and urology.

During 2013/2014, the David Harvey ambulatory unit saw 6,589 new patients with an additional 975 patients returning to the unit for follow-up visits. 11,680 patients attended for new or follow-up outpatient clinics.

During our inspection we spoke with four members of staff. We also spoke with two children and their family who were present in the department at the time of the inspection.

Summary of findings

Both the children's outpatient department and the David Harvey Ambulatory unit were visibly clean and tidy and there were processes in place to regularly monitor the standards of cleaning. There were procedures in place to manage the deteriorating neonate, child or young person. Whilst medical records were kept safely, there was an emerging theme that clinicians did not always have access to full sets of clinical notes or referrals in-time for outpatient clinics.

Children's services followed national evidence-based care and treatment and carried out a small selection of local audits to ensure compliance. However, there was no auditing of care in which the service could be benchmarked either locally or nationally.

Children and those close to them, such as their parents or carers, were involved in the planning of care and treatment and were able to make individual choices on the care they wished to receive. People spoke positively about their experience of using the David Harvey Unit, which during 2013/2014 received a very low number of complaints.

Whilst the department had embraced the wider "Connecting Care 4 Children" initiative, there was little vision or future strategy for the department. There was no evidence to demonstrate that there had been consideration given to alleviating the pressures of the over-subscribed outpatient department located at St Mary's Hospital.

Services for children and young people

Are services for children and young people safe?

Good

Staff demonstrated an awareness of how they should report incidents. Incidents were reviewed and interventions took place to reduce the risk of them occurring again in the future.

The department was clean and was regularly monitored. Medicines were stored and administered correctly. Medical records were handled safely and protected however there were concerns that full sets of medical notes were not always made available in time for clinics, with clinical staff having to rely on temporary sets of notes. Staff demonstrated awareness of the laws surrounding children and young people's consent.

Staff had received mandatory training and there were sufficient numbers of suitably qualified staff to meet children and young people's needs. Equipment and processes were in place to manage children and young people who were acutely unwell or whose condition deteriorated whilst in the department.

Incidents

- Between April 2013 and July 2014, 54 incidents were reported by the service. Six incidents were reported as "minor harm", one as "low harm" and the remaining 47 were reported as "No harm". We spoke with two members of staff who were both able to describe the incidents that had occurred during 2013/2014; they were further able to describe the actions taken by the department to help to mitigate the risk of specific incidents occurring again in the future such as the double-checking of parent contact numbers to ensure they had been accurately recorded.
- All incidents were reported through a centralised electronic reporting system. Senior nurses and consultants reviewed the incidents reported and analysed the data to identify any trends.
- Learning from incidents was disseminated to the staff team in a range of ways with examples including a service wide newsletter called "The Indicator". Staff reported that they discussed incidents and complaints on a weekly basis and action was taken to resolve issues which were repeatedly being reported. However, we found that this governance process was not suitably robust to ensure all staff were informed of incidents; we have discussed this further within the well-led domain of this report.
- The main trend originating from the incidents reported between April 2013 and July 2014 were attributed to the availability of medical records. Following a divisional review of the administrative and clerical structures in January 2014, the number of incidents reported relating to missing or unavailable medical notes was noted to have significantly reduced.
- Whilst morbidity and mortality meetings took place on a monthly basis, it was not possible to determine from the minutes of those meetings whether representatives from the David Harvey ambulatory unit attended the meetings.

Cleanliness, infection control and hygiene

- Staff working in the OPD and David Harvey Unit had a good understanding of responsibilities in relation to cleaning and infection prevention and control.
- All of the staff we observed in the David Harvey Unit were complying with the trust's policies and guidance on the use of personal protective equipment (PPE) and were bare below the elbows.
- The department had a range of equipment, which was seen to be visibly clean and well-maintained. Labels were in use to indicate when items of equipment had been cleaned.
- During our observations of the immediate environment in which children and neonates received treatment and care, we found all areas to be visibly clean.
- A review of incidents identified that the children's outpatient department had reported concerns that rats had caused damage within the department. An update dated 2 June 2014 to an incident which was reported on 6 May 2014 stated that engagement with a specialist pest control team had resolved the issue with no further evidence of rats being present in the department.
- Where cleaning took place, domestic staff were using colour-coded equipment items for different parts of the department.
- There were no reported cases of MRSA or Clostridium Difficile impacting upon the department during 2013/2014.
- The department attained an overall compliance rate of 89.2% with regards to the completion of the peripheral

cannula care bundle during 2013/2014. During April and May 2014 (the most recent data provided to us) the department reported 100% compliance with this care bundle.
- There were systems in place for ensuring that toys were cleaned on a regular basis. Area: Outpatients and David Harvey Unit; Hand Hygiene 2013/14= 100%; Cleaning Score 2013/14= 89.5%.

Environment and equipment
- Equipment was found to be in date and staff told us there was sufficient equipment available at all times.
- Staff were aware of whom to contact or alert if they identified broken equipment or environmental issues that needed attention.
- Age appropriate resuscitation equipment was available and there was evidence that this has been regularly checked.
- The unit was clean, well-lit and had recently been refurbished.

Medicines
- We were told the main medicines administered within the department included pain relief medications and local anaesthetic for minor procedures. We found medicines had been appropriately stored, checked and administered within the department.
- There was a process for monitoring the risks associated with the storage, prescribing, preparing and administration of medicines. Incidents were reported via the trusts incident reporting system. Children services had a dedicated risk and audit nurse whose role, amongst others, was to review recorded incidents to identify trends within incidents and complaints. The departmental risk newsletter "The Indicator" reported the number of incidents reported within paediatrics and neonatology. Where trends had been identified, actions had been taken to resolve issues.

Records
- During our inspection, we noted that records were kept securely.
- A review of recorded reports indicated that the children's outpatient department had experienced problems with having full sets of patient records being made available to the medical and nursing team in time for clinics. A total of 28 incidents were reported between April 2013 and 22 July 2014 which specifically related to notes being unavailable, missing information or information being filed incorrectly.
- Between 10 June 2014 and 2 September 2014, 31 patients were seen in the paediatric outpatient department with a temporary set of notes (3.2% of total visits). There were no reported incidents whereby no records were available during the same time period. However, a review of the recorded incidents indicated that whilst temporary notes were made available, these often lacked relevant clinical information or referral letters and so hindered clinicians when they were reviewing patients.

Consent
- Staff we talked with showed that they understood the concept of Gillick competence and explained that the consent process actively encouraged the involvement of young people in decisions relating to their proposed treatment.

Safeguarding
- Managers and members of staff demonstrated a clear awareness of the referral processes they must follow should a safeguarding concern arise within the outpatient and ambulatory care department.
- A policy relating to safeguarding children and young people was readily available and accessible and had been reviewed in July 2014.
- The hospital had a consultant lead, named nurse and named executive for safeguarding children.
- There were processes in place for ensuring that children who had not attended for an outpatient clinic were followed-up. The nurse-in-charge for outpatients ensured that each child who had not attended was referred back to the consultant who would then consider whether the child should be discharged from the clinic list and referred back to the GP with a covering letter stating that the child did not attend, offered another appointment time (a DNA letter was still sent to the GP) or whether a safeguard referral should be submitted.
- 86% of the consultant team had completed level three safeguarding training. The remaining 14% had attended a recent level 2 course.

- 71% of nursing staff had completed level 3 safeguarding children training. The remaining 29% (2 nurses) had dates confirmed to attend a level 3 course in September and October 2014.
- 100% of the administration and clerical staff who supported the department had attended level 2 or 3 training in line with trust requirements.
- Both play specialists had completed level 3 child safeguard training.

Mandatory training

- 63% of staff had completed their mandatory training. The remaining 37% of staff were booked to attend their three-year update sometime between October and December 2014.

Assessing and responding to patient risk

- The trust used a paediatric early warning score system (PEWS) to ensure the safety and well-being of children. This system enabled staff to monitor a number of indicators that identified if a child's clinical condition was deteriorating and when a higher level of care was required. Staff we spoke with were aware of the appropriate action to be taken if patients scored higher than expected, and patients who required close monitoring and action were identified and cared for appropriately.
- There was a process in place for referring children who presented to the department and who were acutely unwell to more appropriate clinical settings such as the A&E department at St Mary's Hospital.
- Staff had access to protocols issued by the North London specialist children's' acute transport service (CATS). These guidelines were designed to support staff to stabilise the acutely unwell child prior to them being retrieved by CATS or other retrieval services.
- Staff also had access to advanced paediatric life support algorithm's and emergency resuscitation equipment.
- Where children were identified as requiring hospitalisation, processes were in place for commencing first line treatments prior to children being transferred to the children's ward at St Mary's hospital.

Nursing staffing

- Information provided by the trust indicated that as of September 2014, the establishment for the department was seven whole time equivalent (WTE) posts with no vacancies.
- Following the publication of the 2013 Royal College of Nursing guidance on staffing, the senior management team undertook a review of the nursing establishment across the service.
- The department was staffed by qualified nurses from 08:30 to 18:30 Monday to Friday. The department operated with a minimum of four nurses during peak periods, reducing to three nurses during the summer months when it was reported that activity within the unit was lower.
- The year-end sickness rate for the department was reported as 15.8% which was significantly higher than other clinical areas within the children's division. This high level of sickness was attributed to one member of staff being on long-term sick leave.
- Sickness levels for April and May 2014 were reported as being considerably lower at 3.9% and 6.6% respectively (generating a two month average of 5.3%).
- Nursing staff turnover was noted as being consistently low for this department. Ward or clinical Area; David Harvey and Children's Outpatients; 2013/14 Year End Bank/Agency Usage= 8.3%; 2013/14 Year end Vacancy Rate= 0%; 2013/14 Year End Sickness Rate= 15.8%.

Medical staffing

- The department was supported by a lead paediatric consultant.
- A paediatric consultant was present in the ambulatory care unit each day.
- A third party provider also operates a GP service from the unit where children can be referred for the management of minor ailments.
- Children presenting to the Hammersmith Hospital Urgent Care Centre outside of the operating hours of the David Harvey Unit were managed in-line with an agreed clinical pathway which was available on the trust's intranet site.

Major incident awareness and training

- Whilst the trust had a site specific Major Incident Plan, it was not possible to determine the role of the David Harvey unit in the event of the plan being implemented. There was an assumption that all children would be managed initially via the St Marys' paediatric emergency department.

Services for children and young people

Are services for children and young people effective?

Requires improvement

The David Harvey Unit had a very limited range of evidence; a small number of audits were conducted by the service to ensure the clinical interventions they carried out were effective and compliant with the national guidance upon which clinical practice was based. However, there was very little local audit being carried out to robustly demonstrate the overall effectiveness of the service.

Children were seen and treated by a middle-grade or consultant paediatrician upon presentation to the unit. There were policies and guidelines in-place which were consistent with national best practice and based upon recommendations by organisations such as the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH). A small number of audits were conducted by the service to ensure the clinical interventions they carried out were effective and compliant with the national guidance upon which the practice was based.

Children and young people could expect to have their pain assessed and managed appropriately. Staff had received training in immediate and advanced life support techniques and the majority had undergone an appraisal in the preceding 12 months. There was evidence that multi-disciplinary working occurred across both the David Harvey unit and children's outpatients.

Evidence-based care and treatment

- Children's services used a wide range of guidelines which had been produced by the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPCH) to define the treatment they provided.
- There were pathways and protocols of management and care for various medical and surgical conditions. We saw documented evidence that these were used, and updated appropriately if there were any changes in the national guidelines.
- The department had introduced a pathway for the diagnosis and management of urinary tract infections in children. This pathway had been audited in July 2013 to determine the level of compliance against the national guidance (National Institute for Health and Care Excellence: Urinary tract infection in children: Diagnosis, treatment and long-term management: Clinical Guideline 54 August 2007).
- Where improvements were identified such as ensuring two mid-stream urine samples were sent to definitively confirm the presence of a urinary tract infection, actions were taken to reinforce the local policy such as increased awareness amongst staff of the policy and pathway.

Pain relief

- Children and young people had access to a range of oral medicines and local anaesthetic to ensure pain control was effective during procedures.
- The department used an evidence based pain scoring tool to assess the impact of pain. Play specialists were available to provide distraction therapies whilst children underwent procedures such as blood tests.
- Children presenting to the department during an acute pain crisis could be transferred to the main children's in-patient service on the St Marys' Hospital campus where referrals could be made to the specialist paediatric pain service.

Patient outcomes

- There was limited evidence to identify how the department took assurances that the clinical interventions they performed resulted in positive patient outcomes.
- Due to the design and resources applied to The David Harvey Unit, the service was able to meet the standards set by RCPCH in that all children attending the unit were seen by a middle grade or consultant within four hours, daily consultant led handovers occurred, consultant paediatricians were available on the unit every day and specialist paediatricians were available by telephone for support and guidance.

Competent staff

- Six of the seven medical staff who routinely supported the David Harvey Unit had completed training in paediatric intermediate or advanced life support training.
- Only one member of the nursing staff was in receipt an up-to-date accreditation in paediatric intermediate or

advanced life support training. The remaining five nurses working in the unit were due for an update to their training to ensure their skills and knowledge were in-line with national standards.

- 71.9% of nursing staff had undergone an appraisal during 2013/2014.
- 100% of allied health care professionals, unqualified nursing staff and administrative and clerical staff had undergone an appraisal during 2013/2014.
- Members of staff gave positive feedback about the individual support they received regarding their personal development.
- Nurses, doctors and student nurses working in the unit undertook regular emergency scenario training such as the management of a child experiencing seizures or children presenting with asthma emergencies.
- The lead consultant facilitated regular inductions and training sessions to junior medical staff who were undertaking clinical placements within the unit.

Multidisciplinary working

- The ambulatory care unit had processes in place to liaise with specialists located on the St Mary's campus. Staff reported that there was a low threshold for discussing the clinical management of children who presented to the department, as well as there being strong links with the paediatric radiology team.
- Additionally, the unit was supported by a range of allied health professionals including dieticians and speech and language therapists.
- Clinical psychology was available to children who required such referrals or support for behavioural and/or mental health conditions.
- The department operated a monthly family support meeting which was attended by the hospitals' link social worker.
- Children's outpatients facilitated a range of multi-disciplinary clinics including a feeding clinic which was supported by a clinical psychologist, speech and language therapist and a dietician.
- Children and their families were supported by two play specialists who were present to provide a range of services including distraction therapies.

Are services for children and young people caring?

Good

Children, young people and parents told us they felt they received compassionate care with good emotional support. They felt they were fully informed and involved in decisions relating to their treatment and care. The David Harvey Unit attained a score of 97 in July 2014 which was much better than the national average score of 73.

Compassionate care

- Throughout our inspection we observed staff provide compassionate and sensitive care that met the needs of the child, young person and their parent/carers.
- We observed members of staff engage with children and young people which we considered to be friendly and approachable.
- We observed staff interact with children and interactions were age appropriate. Staff were observed to use age appropriate language with children.
- Both the outpatient department and ambulatory care unit allowed for consultations to be completed in privacy within individual consultation and treatment rooms being available.
- The department utilised the national friends and family test to measure patient experience. The David Harvey Unit attained a score of 97 in July 2014 which was much better than the national average score of 73.

Patient understanding and involvement

- We spoke with two children and their parents/carers during our visit to the David Harvey Unit. We were told by both families that they had felt involved in the planning and decisions relating to their care and treatment. Both families said they had been given a range of treatment options and that staff had explained the risks and benefits of each option. We were told they had been given sufficient information to be able to make informed decisions.
- The trust operated an externally accessible website dedicated to children and young people. The website was divided into age-specific areas and included information on what children and young people could expect when they visited outpatients as an example.
- Informational videos were available which described certain procedures which would likely be carried out in the outpatients department including but not limited to blood tests and ultrasounds.

Services for children and young people

Emotional support

- Parents told us they had been well supported during their visit to the David Harvey Unit.

Are services for children and young people responsive?

Good

The ambulatory care model of the David Harvey Unit provided an easily accessible resource to the local population, which enabled hospital admissions to be reduced.

Staff working in the David Harvey Unit spoke positively about the trust's "Connecting Care for Children" initiative which was established by the children's team at St Mary's Hospital. GPs could access consultant paediatricians via telephone and email, with a same-day response to help reduce the use of unscheduled services such as the A&E department and the general children's ward.

Learning from complaints was disseminated to the whole team in order to improve patient experience within the department.

Service planning and delivery to meet the needs of local people

- Paediatric site practitioners had been employed to oversee the day-to-day operational running of children's services across Imperial College Healthcare NHS Trust, having input into the admissions and discharges of each clinical area. This included liaising with the staff working in the David Harvey Unit whereby children may potentially require admission to a ward at St Mary's Hospital
- The staff working in the David Harvey Unit spoke positively about the trust's "Connecting Care for Children" initiative which was established by the children's team at St Mary's Hospital. This initiative had been designed to assist in the integration of child healthcare across primary, secondary and tertiary services. As a three component programme, the intention was to provide primary care providers with access to specialist paediatric advice by way of the hospital team delivering community led surgeries incorporating education, training, professional support and outreach clinics. In addition, GPs could access consultant paediatricians via telephone and email, with a same-day response to help reduce the use of unscheduled services such as the A&E department and the general children's ward. The final component of Connecting Care for Children was designed to empower patients and their parents/carers to self-manage their own care, to provide peer support to others and to engage with local GPs and primary care nursing staff by acting as practice champions. The David Harvey Unit was reported to be involved in the scheme and was in discussions with a third party provider who had recently established a new local health and wellbeing centre. The David Harvey Unit was seeking to establish a multi-disciplinary meeting and clinic attended by local GP's, health visitors and general practitioners.
- It was acknowledged by the senior management team that the David Harvey Unit had capacity to provide additional services to the local population. Whilst providing a service to the local population, the limited opening hours meant that the service could not fully meet the needs of local people. Staff working in the unit told us that the peak time for children attending primary and secondary care was around 7pm at which time, the David Harvey Unit had closed.
- Whilst some clinics and afterschool appointments were offered, the early closure of the unit restricted the number of children that could be seen once they had finished their school day.
- The demographic of patients accessing the service was, in the main, children aged less than five years (75% of total cases) with 30% being under one. The service reported that almost one in five children who attend the unit were younger than four weeks of age.

Access and flow

- The outpatients department facilitated 11,680 new and/or follow-up appointments during 2013/2014.
- Overall "Did Not Attend" (DNA) rates for children's outpatients during 2013/2014 were reported as 3.6%.
- The highest DNA rate was seen in paediatric surgery (14% of combined new and follow-up appointments) followed by paediatric audiological medicine (10.6% of combined new and follow-up appointments). It is however important to note that the total numbers of referrals made to these clinics were relatively low when compared to general paediatrics with 519 and 82 children referred respectively for paediatric surgery and paediatric audiological medicine.

Services for children and young people

- 11,021 children were referred to general paediatrics, of which 317 did not attend for their initial or follow-up appointment during 2013/2014.
- To address the high DNA rates, the outpatients department had considered a range of initiatives including the re-launching of mobile phone text reminders. Administrative staff had also been employed on a temporary basis whose sole role was to contact families by phone to remind them of their up-coming appointment.
- 21.6% of paediatric outpatient clinics were cancelled during 2013/2014. Some clinics were cancelled due to no patients being booked due to the low number of referrals.
- 7,564 children attended the David Harvey Unit during 2013/2014 of which 6,589 were new attendances and 975 were follow-up visits.
- Due to the configuration of the David Harvey Unit and to maintain patient safety, the trust has engaged with the London Ambulance Service to ensure that children who present with a PEWS score above 5 were transferred directly to the A&E department at St Mary's hospital.
- Between 1 April and 31 August 2014, 17 patients were transferred from the David Harvey Unit to the paediatric A&E department at St Mary's Hospital. During the same time, 40 children were admitted directly from the David Harvey Unit to one of the three children's wards at St Mary's Hospital, with the highest proportion of children admitted to the children ward, followed by the paediatric short-stay unit and then then specialist infectious diseases/bone marrow transplant ward.
- The service was not collating information on waiting times within the David Harvey Unit so it was not possible to measure how responsive the service was to individual needs.

Meeting people's individual needs

- The unit is located adjacent to two large residential areas; children and their parents/carers were able to walk directly into the service to receive care and treatment. The unit was able to provide telephone support to a range of health care professionals including local general practitioners and midwives. Where it was considered that children and young people could benefit from receiving a clinical opinion from a consultant paediatrician, they could be referred to the unit where it will be arranged for them to be seen on the same or next day depending on their clinical need.
- Patient information leaflets were available although it was noted that they were only available in English.
- Staff told us there was no dedicated adolescent waiting area. Adolescents would be seen and treated in areas away from smaller children and babies with examples of them being seen in the GPs consulting room if it was available.
- Adolescents were offered the choice of being seen and treated with or without their parents being present; this was dependent on their personal choice and whether the medical professional considered that the individual was competent to make decisions for themselves. Chaperones were available for those adolescents who chose to be seen without their parents/carer's being present.
- The David Harvey Unit had a small number of children with complex and chronic health conditions who routinely visited the unit. These children were known to the staff group and their medical records were kept within the unit for ease of access and to enable staff to provide consistent care.
- By adopting the ambulatory care model, the David Harvey Unit provided a useful resource to the local population. Hospital admissions were reduced because children requiring short term treatments such as intravenous antibiotics can be assessed, initially treated and then discharged home from the unit on the same day, with follow-up appointments for subsequent doses of antibiotics being provided in the unit until the course of treatment had been completed.

Learning from complaints and concerns

- Information was available for patients to access on how to make a complaint and how to access the patient advice and liaison service (PALS). A dedicated member of staff within each of the clinical areas, including the deputy divisional nurse, reviewed all formal complaints received and concerns raised with PALS. All concerns raised were investigated and there was a centralised recording tool in place to identify any trends emerging. Learning from complaints was disseminated to the whole team in order to improve patient experience within the department.
- The David Harvey Unit received one complaint which had triggered a change to a clinical guideline. This

guideline remained at draft stage. It was reported that the service had, as part of the complaint resolution process, engaged with the complainant in the review of the guideline.e>

Are services for children and young people well-led?

Requires improvement

The children's department had embraced the "Connecting Care 4 Children" initiative which had been established by the children's team at St Mary's Hospital. However, the unit had little vision for the future. There was limited engagement with the children and young person services at trust level and this had been acknowledged by the senior management team. There was no robust evidence to determine how the unit assessed its clinical effectiveness nor was there a strategy for determining how the service might meet the needs of the local population in years to come. This included the lack of engagement with the local population to determine whether the unit could or should be open for longer to ensure it was accessible to school age children out-side of school hours.

There was no formal process for monitoring the quality of the service. Whilst the department utilised the friends and family test, there was no overall quality measure to help the service to determine its effectiveness.

Weekly team meetings occurred where incidents and/or complaints were discussed. There was a culture of openness and flexibility which placed the child and family at the centre of decision making processes.

Vision and strategy for this service

- The vision for the David Harvey Unit was closely inter-woven into the delivery of the "Connecting Care 4 Children Initiative". The establishment and on-going development of multi-disciplinary clinics with primary care practitioners was seen as a priority for the unit.
- The senior management team acknowledged that the David Harvey Unit had the potential to provide a wider range of services compared with the services it currently provides. At the time of the inspection the lead nurse was in the process of evaluating the service to determine how it could be better utilised in the future.

Governance, risk management and quality measurement

- Divisional governance meetings took place and there was discussion regarding incidents and complaints.
- The women's and children's directorate operated a risk register which was seen to be reviewed on a monthly basis via the divisional quality and safety meeting. There were no risks associated with the David Harvey Unit recorded on the divisional register.
- Weekly team meetings took place whereby incidents and complaints were discussed and reviewed amongst the multi-professional team. However, the system for relaying information regarding trends of incidents and complaints amongst staff who worked part time, and therefore not present for the weekly meeting, was informal. There was a reliance on the lead consultant to disseminate information to all those individuals not present however there was no evidence to demonstrate that this occurred. Whilst generic information and common themes were shared within the "Indicator" newsletter, individual incidents such as those potentially affecting the David Harvey Unit were not included within the newsletter.
- Daily meetings facilitated by the consultant paediatrician also took place. Staff told us that these meetings were used as a means of assessing the activity of the unit during the previous day and to review the care that was provided.
- Whilst the department monitored their annual activity including the source of referrals, there were no robust processes in place for monitoring the overall quality of the service. There was a reliance on the friends and family test as a means of seeking feedback from patients and families/carers. The David Harvey Unit was not routinely collating data such as the time taken to triage and initially assess patients as an example. Waiting times were not routinely collected, nor was the time it took for patients to be treated and discharged. The service reported that all patients were assessed, treated, admitted or discharged within four hours, except in a small number of cases where children may be nursed on the unit for more than four hours in order that they could undergo fluid challenges for example.

Services for children and young people

Leadership of service

- There was a leadership structure within the department. A consistent consultant paediatrician presence within the department was seen as having a positive impact by staff working in the department.
- The unit manager was on long-term absence during the inspection and so a member of the nursing team was "acting-up" in the role.
- Staff reported that the lead nurse for children's services who was predominantly based on the St Mary's Hospital campus was "approachable" and "friendly". The lead nurse told us that they spent one day each week visiting the David Harvey Unit and children's outpatient because they felt it important that the service be fully integrated into the trust's children's services.

Culture within the service

- Staff retention was seen as being very good within the department.
- We found there was a culture of openness and flexibility. Staff within the outpatient department spoke positively about the service they provided for children, young people and parents. Placing the child and the family at the centre of their care was seen as a priority and everyone's responsibility.

Innovation, improvement and sustainability

- Whilst the department has engaged in the "Connecting Care 4 Children" programme, there was very limited evidence of how the service was going to improve and remain viable for the future. We acknowledge that the David Harvey Unit is a valuable asset to the local population to which it serves, with it being well resourced with knowledgeable practitioners providing services in a clean, bright and functional environment. However, the limited opening times of the unit placed heavy restrictions on people being able to access those services.
- Furthermore, there appeared to be little engagement with children's services at St Mary's Hospital in addressing capacity issues, specifically in children's outpatients. We have reported on the capacity restraints of the existing outpatients department at St Mary's Hospital within a separate location report. However, it was reported that the outpatients department located next to David Harvey operated routinely with five clinics at any one time; yet the department had the capacity for eight clinics to run. There had been no feasibility study or survey conducted to determine whether the provision of additional outpatient clinics would be a viable option if they were hosted at Hammersmith Hospital.

End of life care

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

Information about the service

Hammersmith Hospital's specialist palliative care team (SPCT) comprised a palliative care consultant and 2.8 whole time equivalent (WTE) clinical nurse specialists. There was also a medical palliative care lead and a nursing team leader, whose roles encompassed the trust's three acute hospital sites. They were part of an SPCT that covered Imperial College Healthcare NHS Trust's three acute hospital sites: St Mary's Hospital, Charing Cross Hospital and Hammersmith Hospital. As such, they shared policies, practices, documentation and held joint multidisciplinary team meetings.

The Hammersmith Hospital's SPCT was involved with 515 cases in 2013/14 and about 50% of hospital deaths. The team's input ranged from giving advice and support to ward staff on the management of palliative care for patients through to directly assessing and monitoring complex palliative care cases.

The team visited patients on a variety of wards, including elderly care, renal, haematology and cardiac. They liaised with ward staff, patients' families and community services with the aim of ensuring that patients' palliative care was delivered efficiently and in accordance with patients' wishes.

Summary of findings

There was an inconsistent approach to the completion of 'do not attempt cardiopulmonary resuscitation' (DNA CPR) forms. In line with national recommendations, the Liverpool Care Pathway for end of life care had been replaced with a new end of life care pathway framework that had been implemented across the hospital. Action had been taken in response to the National Care of the Dying Audit for Hospitals 2013, which found the trust did not achieve the majority of the organisational indicators in this audit, but there was no formal action plan. However, the majority of the clinical indicators in this audit were met.

There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. The specialist palliative care team (SPCT) were visible on the wards and supported the care of deteriorating patients and pain management. Services were provided in a way that promoted patient centred care and were responsive to the individual's needs. Referrals for end of life care were responded to in a timely manner and the team provide appropriate levels of support dependent on the needs of the individual.

There was clear leadership for end of life care and a structure for end of life care to be represented at board level through the director of nursing.

End of life care

Are end of life care services safe?

Requires Improvement

There was an inconsistent approach to the completion of 'do not attempt cardiopulmonary resuscitation' (DNA CPR) forms. Only one of the four DNA CPR forms where patients were receiving end of life care had been completed correctly. Three had not been fully completed.

The SPCT had not reported any serious incidents. When incidents relating to end of life or palliative care patients were reported by ward staff, these were investigated and action taken to reduce the risk of a similar incident recurring. Arrangements were in place for medicines to be provided if patient conditions deteriorated. The SPCT involved family members in decisions that related to their relative's care and treatment. Staff had attended safeguarding training, but were unclear what level of safeguarding training this was or whether this was appropriate for their role. Staff felt confident about reporting safeguarding concerns and were aware of who to raise these with.

Incidents

- There had been no incidents, Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) or incidents requiring investigation that could be attributed to the SPCT.
- Staff were aware of how to report an incident or raise a concern.
- Incidents were reviewed and discussed every two weeks at the multidisciplinary SPCT meeting to identify and share learning.

Medicines

- We were told there were nurse prescribers in the SPCT. The records of patients receiving palliative care or who were being seen by the SPCT on a number of medical wards showed that arrangements were in place for medicines to be provided if patient conditions deteriorated and they required medicine to relieve symptoms. Prescriptions were written up in anticipation and therefore could be given in a timely manner.
- Medicines were available on the wards.
- The medical lead for the SPCT told us they were aware there had been issues that related to the prescribing of opioids within the hospital. These issues included conversation of dosage when the drug was administered via different methods, such as injection or syringe drivers. To mitigate this risk the SPCT produced an opioid conversion chart. This was credit-card sized and converted differing opioid doses to enhance patient safety. Feedback from the medical staff we spoke with were positive about its effectiveness.
- In response to the National Care of the Dying Audit for Hospitals 2013 the trust were trialling a system in relation to prescribing medication delivered via syringe drivers. This included the use of 'syringe driver prescription' stickers, which were pre-printed and aimed to make the identification of medications delivered via this method easy to identify. The pilot was being audited at the time of our inspection.

Records

- Some patients receiving end of life care had been identified as 'not for resuscitation'. While patients had a copy of the DNA CPR form in their file so staff were aware of what action to take in the event of their cardiac or respiratory function ceasing this was not always fully completed.
- We reviewed the four available DNA CPR forms on wards where patients were receiving end of life care. Only one of these forms had been completed fully and correctly. Missing information on these DNR CPR forms included a record of the discussions with patients on that had taken place. In one file we found that the consultation between the patient and their family had taken place with social workers, nurses, a dietician, junior and senior doctors. This had been documented in the patient's case notes. However, the agreed discontinuation of treatment and palliative care was not documented on the DNA CPR form.
- People's individual preferences were noted in the SPCT's hospital multidisciplinary meeting record. This included spiritual preferences, goals, social and family involvement and whether the patient had signed a DNA CPR form. We were told that, once this was completed, a sticker copy of the record was stuck in the patient's notes. However, the hospital had run out of stickers at the time of our visit.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The SPCT involved family members in decisions that related to a patient's care and treatment.

End of life care

- Independent mental capacity advocates attended SPCT multidisciplinary meetings and contributed to discussions about treatment and discharge destinations, best interests and informal decisions.
- In all notes we looked at patients' capacity to consent was recorded.

Safeguarding

- Staff had attended safeguarding training, although, the SPCT leadership were unable to tell us what level of training had been undertaken.
- We were given examples by medical and nursing leads for the SPCT which demonstrated they had raised and discussed concerns about potential abuse and vulnerability in multidisciplinary team meetings. Cases had been referred to the hospital safeguarding lead. This included issues of financial abuse, concerns about patients' children, suicidal and elderly patients. They were able to easily locate the safeguarding referral form on the trust's intranet.

Mandatory training

- Staff were required to attend a three-day training course that covered mandatory training every three years. There were also other courses completed annually. Topics included infection prevention and control, fire safety, information governance and mental health and capacity.
- Attendance was monitored and recorded centrally within the trust. If staff had not attended, managers were contacted. Attendance was reviewed in annual appraisals and objectives could not be judged as 'met' unless staff had fulfilled this requirement.

Assessing and responding to patient risk

- Ward staff told us the SPCT was visible on the wards and supported the management of deteriorating patients. The team was also available by phone for advice and verbal referrals. Nurses also told us they were able to contact the SPCT out of hours and showed us the numbers they had for contacting them.
- Ward staff told us deteriorating patients were identified by nurses and highlighted to the doctors. These patients would have a multidisciplinary review which involved the SPCT.
- The results of the National Care of the Dying Audit 2012/13 showed that 75 % of patients were identified for end of life care when they were dying. This was better than the England average of 61%. The trust scored better than the national average for those patients who had been assessed within their last 24 hours, with 94 % compared to the England average of 82%.
- There were informal arrangements such as direct contact by ward staff to the SPCT to refer patients for end of life care or seek advice. There was no electronic flagging to know how many patients were receiving end of life care.
- There was a system for grading the level of input required from the SPCT; it was unclear how this grading informed the team's response to patient risk.

Nursing staffing

- There were a total of 7.8 WTE clinical nurse specialists in the trust's SPCT, with 2.8 posts based at Hammersmith Hospital. They were rotated annually across the sites to promote the trust-wide approach to palliative care.
- There had not been an assessment to determine nurse staffing in the SPCT, current staffing levels were historical.

Medical staffing

- There was a palliative care consultant based at the hospital and a medical lead within the SPCT that covered all three sites. This was in line with the Association for Palliative Medicine of Great Britain and Ireland recommendations, and the National Council for Palliative Care which states there should be a minimum of one consultant per 250 beds.
- There was an out-of-hours rota shared by the four consultants which ensured staff had access to the SPCT at all times.

Major incident awareness and training

- The medical lead for the SPCT told us they had completed the trust's major incident awareness training last year and had contributed to the major incident team's planning process.

End of life care

Are end of life care services effective?

Good

The Liverpool Care Pathway had been withdrawn in line with national recommendations and had been replaced with care pathway that had been approved by the trust's end of life steering group and professional practice committee.

Ward staff were trained in end of life care. Patients' pain was being appropriately managed. Annual appraisals were taking place for all SPCT staff. We found good examples of multidisciplinary working and there was an on-call rota that covered seven days.

Evidence-based care and treatment

- The SPCT withdrew the Liverpool Care Pathway in July 2013 as soon as the announcement regarding its withdrawal was issued by the Department of Health.
- A new end of life care pathway was subsequently produced by the SPCT that had been agreed through the end of life steering group chaired by the trust's director of nursing. This was rolled out across the hospital wards. It included a principles document and a multidisciplinary decision document. We were told this had been ratified by the professional practice committee and was due for imminent sign-off by the quality and safety executive committee. Ward staff told us the SPCT had visited wards specifically to familiarise staff with the principles and use of the new care pathway documentation. Staff we spoke with on the wards were aware of the new end of life pathway documentation and had been trained by the SPCT in its use. Nurses told us they were happy with the documentation.
- There were no patients on the end of life care pathway on any of the wards we visited. We were therefore unable to review the pathway's practical application.
- The SPCT medical lead was required to verify with the trust's clinical quality assurance manager that the service was compliant with National Institute for Health and Care Excellence (NICE) guidance.
- The SPCT retrospectively measured the level of input they had had with each patient. These were graded from 1 (offering advice and acting as a resource for ward staff) to 4 (directly assessing and monitoring complex palliative care). Their annual report for 2013/14 demonstrated that 86% of referrals were graded as a 3 or 4. There were 515 referrals to the SPCT from Hammersmith Hospital.

Pain relief

- We found pain relief medication had been prescribed by medical staff and given appropriately by nursing staff. Patients' notes demonstrated that pain was being managed appropriately and we observed an SPCT clinical nurse specialist speak about pain relief with patients. The SPCT gave advice about pain management to ward staff.
- One relative we spoke with told us they were happy with the way their loved one's pain was being managed.
- All junior doctors had been given opioid conversion cards to aid conversion of medication from oral to ventral by injection.

Nutrition and hydration

- Nutrition and hydration needs were included in end of life care documentation.
- Patients' hydration needs were taken care of. One relative told us they were happy with the nutrition and hydration care of their loved one.

Patient outcomes

- The National Care of the Dying Audit for Hospitals 2013 found that the trust had achieved better than the England average for seven out of ten clinical key performance indicators and scored worse for one indicator.
- The SPCT participated in the National Care of the Dying Audit and received the results in May 2014. Actions were being taken on its key recommendations. These included auditing syringe driver use, having a board member with responsibility for end of life care and reviewing protocols for DNA CPR forms.
- The SPCT lead told us a formal action plan in response to the National Care of the Dying Audit had been delayed because the trust wanted to produce a comprehensive improvement plan for palliative care services. They had very recently commissioned an independent service review that was carried out by Macmillan. The preliminary findings were received by the trust the week prior to our visit. It was the trust's intention to formulate its strategy and improvement

plans on the basis of the improvement plan and independent review. We were told by the director of nursing that any actions from the current CQC report would also be incorporated in this.

Competent staff

- Training attendance for all SPCT staff was reviewed in annual appraisals and objectives could not be judged as met unless staff had fulfilled their training requirements.
- SPCT staff told us they saw part of their role as always being available to ward staff to give advice and share expertise. Ward staff told us they felt more competent to care for patients at the end of life as a result of this support.
- Ward staff told us that SPCT staff were easy to contact and responded promptly to their requests for support and advice. They also told us the SPCT had carried out training on using the new end of life care pathway documentation on the wards. Other ward staff had received additional end of life training, for example, through attendance on the postgraduate end of life care module or the four-day course run by the trust. We were told they felt supported by the hospital to do this additional training which enabled them to provide support for junior nurses and healthcare support workers. On Dacie Ward, the sample of training records we looked at showed that nine of 24 ward staff had completed the four-day palliative care training course to allow some staff to have specialist training.
- A junior doctor we spoke with had received training in end of life care that included care planning, pathways and DNA CPR. All new staff to the trust had end of life care training as part of their induction and staff in patient affairs were trained in dealing with bereavement and loss.

Multidisciplinary working

- Regular SPCT multidisciplinary team meetings included nursing and medical staff from all three hospital sites that provided palliative care within the trust.
- Members of the SPCT also attended board rounds and ward rounds on hospital wards in order to have clinical input with palliative care patients and pick up new referrals.
- SPCT members maintained relationships with other groups with an interest in palliative care. They attended hospice multidisciplinary team meetings, maintained contact with community teams, and attended meetings with the local authority end of life steering group and with local clinical commissioning groups.

Seven-day services

- The SPCT ran a clinical nurse specialist service from Monday to Friday between 8am and 5pm. Medical cover was available on site between 8am and 8pm. There was an on-call palliative care consultant on rota out of hours. We were told that between three to six calls per day were received at weekends through the on-call system, mostly for advice about pain relief for patients.
- Ward staff had the contact details of the on-call service displayed in nursing offices and told us they felt supported by this service.

Are end of life care services caring?

Good

Patients and relatives told us the hospital delivered compassionate and caring treatment to palliative care patients. Ward staff demonstrated the need for care and compassion when caring for end of life and palliative care patients.

SPCT staff were compassionate and caring in their interactions with patients and relatives and supported people's wishes and preferences for how they wished to be treated and cared for.

Compassionate care

- Mortuary staff described to us the compassion and consideration they gave to relatives of the deceased. This included speaking to them about what to expect when they came to view their loved ones in the mortuary viewing area. They also told us they would sit with relatives if this was needed.
- Porters demonstrated the process for transporting a body between the ward and mortuary. This included maintaining the deceased dignity by ensuring the body was transported from the wards on a trolley with covered side frames in an enclosed electric vehicle.
- Ward staff demonstrated the need for care and compassion when caring for end of life and palliative care patients.

End of life care

- The SPCT told us about the need to work with sensitivity and compassion at what was a difficult time for people. We observed an SPCT clinical nurse specialist having conversations with patients and relatives that were sensitive and compassionate.
- Relatives we spoke with told us they felt staff treated their loved ones with care and compassion.
- Staff from patient affairs accompanied people to the mortuary viewing room. They demonstrated their sensitivity to people's needs.
- We observed an SPCT clinical nurse specialist contact a nearest relative by phone to tell them their loved one was not well enough to return home. This was a compassionate and sensitive conversation. The reasons for this clinical decision were clearly explained to the relative.

Patient understanding and involvement

- The SPCT told us they saw part of their role as advocating for patients and their relatives on the wards. For instance, helping to arrange single rooms for people where this was their choice.
- Medical records demonstrated patients and their relatives' views were taken into consideration in the way they were treated and cared for. For instance, people's views were sought during ward rounds.
- The SPCT had a policy of always supporting patients' choice of preferred place of care and preferred place of death, although community resources meant this was not always achievable. The team succeeded in enabling patients' choices 80% of the time.
- We observed an SPCT clinical nurse specialist have a conversation with a patient and their relative. They discussed the circumstances of the admission, the patient's condition and pain management. Their medical diagnosis was discussed with sensitivity.
- As well as promoting family/carers involvement in patients' care, independent mental capacity advocates attended the SPCT multidisciplinary team meetings. This was to support patients to make informed decisions about their care. Patients' wishes were documented on the SPCT multidisciplinary form and in their medical records.

Emotional support

- The clinical nurse specialists were psychology trained. They demonstrated the need to support patients, staff and relatives emotionally. The end of life strategy also stated that psychological support be offered to people in the last days of their life. SPCT multidisciplinary meetings discussed patients' emotional and psychological needs to ensure these were met. There was a counselling service available for oncology patients and their relatives.
- Chaplains were accessible and saw anyone who wanted to be seen. Staff told us they found this to be a helpful friendly service.
- There was a staff counselling service available which staff knew how to access.

Are end of life care services responsive?

Good

Services were provided in a way that promoted patient centred care and were responsive to the individual's needs. Referrals for end of life care were responded to in a timely manner and the team provide appropriate levels of support dependent on the needs of the individual.

Action had been taken in response to complaints relating to end of life care to reduce the risk of a similar complaint being received. Arrangements were in place to provide interpreter services for people.

Service planning and delivery to meet the needs of local people

- The SPCT nurse lead had recently completed an audit to understand the team's response to referrals. This showed that, from the time the SPCT were called to the time they had first face-to-face contact with a patient or member of staff (dependent on the level of need) there was an average of 2.25 hours for Hammersmith Hospital. The trust's average was 2.3 hours.
- The SPCT also measured the level of input they had with each patient. This enabled them to understand how they had responded to individual needs. The level of input was graded from 1 (offering advice and acting as a resource for ward staff) to 4 (directly assessing and monitoring complex palliative care). Of all referrals, 86% were graded as a 3 or 4.
- The SPCT measured their success rate in achieving patients' preferred place of care and preferred place of death. This was 80% at Hammersmith Hospital.

End of life care

- The hospital was able to offer relatives reasonably priced accommodation in a block of flats nearby. The trust's shuttle bus service ran between the trust's hospitals and was available to people staying there.
- Mortuary staff told us they had adequate fridge space. There were also other mortuaries within the trust they could use as a resource and a private company it was possible to outsource to if required.
- When a patient died, the hospital's information system had a facility to cancel their future appointments, avoiding relatives receiving hospital appointments for the deceased.

Access and flow

- The National Care of the Dying Audit for Hospitals 2013, found that the trust did not achieve the performance indicator that patients had access to specialist care in the last hours of life.
- The trust's discharge team worked with the SPCT to support people's preferred place of care and preferred place of death. The team were involved in 95% of the hospital's fast-track referrals for discharge. The trust aim to obtain funding for rapid discharge with four hours and a placement found within 24 hours. However, we were given examples where access to home equipment or hospice placements had been difficult and resulted in delays outside the hospital's control.
- We observed the SPCT involved in the rapid discharge of a patient on Frasier Gamble Ward with the relevant paperwork completed. Another rapid discharge had been delayed because it took a week to deliver a mattress.
- The trust had a policy not to move patients receiving palliative care between wards at night. We were not provided with information to demonstrate that end of life patients were not moved after 10pm.
- We found examples where patient conditions had rapidly deteriorated to the point where a clinical decision had been made not to move the patient from hospital so they did not die in transit. We observed the SPCT clinical nurse specialist explaining this clinical decision to the patient's relative.
- Capacity in the mortuary was well-managed. The mortuary maintained good links with patient affairs and staff were aware of how to contact relatives to have them arrange for removal of bodies from the ward to the mortuary considering cultural and religious aspects.

Meeting people's individual needs

- We were told the SPCT rarely had contact with patients with a learning disability. If they did, we were told they immediately contacted the person's community support network and family to get up-to-date information regarding that person's preferences and needs.
- Information leaflets were available in the bereavement office on benefits, arranging funerals and funeral funding.
- A senior ward nurse told us they were well-supported by the SPCT which was responsive to people's needs. Other staff told us the SPCT was responsive and helpful when called.
- The SPCT liaised with carers and care homes and the lead dementia nurse for the trust. Care planning for patients was addressed within this wider support network. For instance, mental capacity issues, treatment options and discharge planning were all addressed as they were the responsibility of the care of the elderly and medical teams.
- We found side rooms were available to patients receiving end of life care when we visited the wards. Patients receiving end of life care would be accommodated in side rooms when it was appropriate and rooms were available. The SPCT lead nurse told us their staff spoke to ward managers when they felt this option was more appropriate for patients.
- There were no visiting restrictions for end of life patients. We also found relatives were able to stay overnight with their loved ones when accommodated in a single room. In addition, the hospital offered relatives reasonably priced accommodation in a block of flats nearby. The trust's shuttle bus service ran between the trust's hospitals and was available to people staying there. There were also quiet rooms available on wards for holding sensitive conversations and for breaking bad news to patients and relatives.
- There was a telephone interpreting system available. We were also told there was an internal interpreting resource available provided by bilingual health professionals employed by the trust. If an interpreting service was needed for an uncommon language it would be outsourced.
- Chaplains demonstrated knowledge of the translator services available. One gave an example of finding a Slovak chapel in the community for one patient. The Muslim chaplain spoke Arabic, French, Spanish and English.

End of life care

- The chaplaincy attended the SPCT multidisciplinary team meetings at the hospital and input from all major faiths was available. The chaplaincy coordinated work between the three acute hospitals within the trust. We met a number of chaplains during our visit who were interacting with patients. The pro forma for recording all SPCT multidisciplinary discussions included addressing cultural and spiritual needs.
- Chaplains had an on-call rota and aimed to respond within two hours. Funding cuts meant that, when a female Muslim chaplain left, she was replaced by someone contracted for a reduced number of hours (10 hours a week). However, the chaplain told us that she had worked many more hours to meet the demands of the job. The Catholic chaplain felt there was a lack of Jewish input for patients as they were only contracted for seven hours a week. We were told the trust was looking in to the possibility of employing one chaplain to cover multi-faiths as a cost-saving exercise.
- The Muslim prayer room was secured by a coded lock. The combination had been changed without people knowing the combination. To gain access, we were led around the back and up a metal fire escape staircase. This was an established method for entry and made the prayer room inaccessible to many due to mobility issues. It also relied on prior knowledge of how to find the room, which was slightly obscure and not signposted. The female prayer room was around one-fifth of the size of the men's. There were three washrooms for men, one for women. We were told by the chaplain that this was incommensurate with the level of use. We visited the multi-faith prayer room and observed it to be basic but clean and pleasant.
- Posters about the availability of chaplains were on display on the wards. There was a chaplaincy newsletter about multi-faith services.
- The National Care of the Dying Audit for Hospitals 2013found that 39 % of patients had a spiritual needs assessment at the trust; this was similar to the England average.
- The mortuary viewing area was well-maintained and was available for relatives at all times through the site managers. The area was well-lit and clean. There were enough chairs for people and the room had a window.
- When a patient died, the hospital's information system had a mechanism to cancel their future appointments to avoid their family receiving hospital notifications through the post after their death.
- Information leaflets and benefits advice were available from staff working in the Macmillan office space.

Learning from complaints and concerns

- We were told that the SPCT had not received any complaints in the last year. Trust-wide, 4% of complaints related to patients receiving end of life care, the majority of these complaints related to poor communication and decisions regarding care and treatment. To reduce the risk of similar complaints being made the SPCT had delivered presentations on the issues faced by patients and relatives at the end of life to ward staff. However, there was no evidence to demonstrate that this action had been effective in preventing similar complaints being received.
- We were provided with examples of where the SPCT had liaised with wards when patients' relatives were unhappy with aspects of care. We were told that the SPCT's intervention was a supportive role for both relatives and staff when there were heightened emotions and difficult conversations about palliative care.

Are end of life care services well-led?

Good

Action had been taken in response to the National Care of the Dying Audit for Hospitals 2013, which found the majority of the organisational indicators were not met but no formal action plan had been developed. However, the majority of the clinical indicators in this audit were met. There was limited evidence of how the view of patients and their relatives were obtained.

There was a recently developed end of life strategy and identified leadership for end of life care. The end of life steering group reported to executive committee. There was an annual audit programme and the service contributed to national data sets.

Vision and strategy for this service

- The end of life care strategy developed in 2014 by the end of life steering group was based on national guidance such as on the National Institute for Health and Care Excellence (NICE) quality standard 13, and the Department of Health's National End of Life Care Strategy.

End of life care

- In response to the National Care of the Dying Audit, that found there was no executive lead for end of life. The director of nursing was identified as the executive lead for end of life care and chaired the end of life steering group from May 2014.
- The end of life steering group met monthly and had representative from across the hospital, including junior doctors, allied healthcare professions, nurses and chaplains.

Governance, risk management and quality measurement

- The National Care of the Dying Audit for Hospitals 2013 found that the trust had not achieved six of the seven of the organisational key performance indicators (KPIs) and made nine key recommendations for the trust. There was no action plan detailing the delivery of these key recommendations. We found during our inspection that action had been taken to address some recommendations but had not been reported through formal governance arrangements.
- The end of life steering group reported to the executive committee through the director of nursing who was also the chair of the group.
- There was an annual audit programme and audits completed this year included syringe driver sticker audit, SPCT response times to referrals and hospice waiting times. Planned audits for later this year included Pro Re Nata (PRN, or as required) drugs administration, fast-track discharge and syringe driver set-up times. Some action plans had been developed following audits to address shortfalls.
- Audit results were presented at the monthly cancer directorate morbidity and mortality meetings. It was unclear how learning from audits was shared with other directorates in the hospital.
- The SPCT participated in the London Cancer Alliance (West and South London group) work programme including the palliative care and the psychological work stream, which aimed to share learning, practice and service improvements.

Leadership of service

- The SPCT had a medical lead supported by a consultant based at each hospital site. The team also had a clinical nurse specialist team leader, with clinical nurse specialists based at each hospital site.
- The SPCT team leader and medical lead regularly visited all three sites and were aware of issues relating to their service.
- There were some systems in place to ensure a consistency of approach by all staff caring for patients at the end of their life. For example, all ward staff we spoke with were aware of the new end of life care pathway documentation.

Culture within the service

- The SPCT leadership team told us they nurtured a culture of helpfulness, accessibility and openness. Ward staff told us they found the SPCT members to be accessible, helpful and approachable. We were also told they fulfilled an educational and advisory role whenever they were called on.
- The SPCT aimed to achieve a culture that had the same attitudes and values, culture and practice across all three hospitals. They held joint meetings and shared pathways, processes and documentation. They had also introduced an annual staff rotation between the hospitals for clinical nurse specialists.

Public and staff engagement

- The patient experience committee fed into the oncology patient experience group. Minutes showed that meetings were held every two months and patients were represented alongside trust leads and matrons.
- We were told by the SPCT medical lead that they had faced difficulty getting feedback from people who had come in to contact with their service due to the sensitive nature of death for people's relatives and carers. In 2011/12 the team tried to implement a patient questionnaire without any success. The team had recently approached a clinical psychologist to explore how feedback could be obtained.
- The clinical psychologist found that relatives reported that they were too exhausted following a bereavement to give feedback about the service. In response, the service had recently completed a piece of work with information governance and patient affairs. This will involve the patient affairs team obtaining consent from relatives to send them a questionnaire six weeks after the death of their relative, asking for feedback on their experience of the service. As this initiative had only recently been introduced we were unable to assess its effectiveness or if concerns raised by relatives were addressed.

End of life care

Innovation, improvement and sustainability

- To make improvements to the service participated in the National Council for Palliative Care's minimum data set collection. This information compared the service with other palliative care services and fed in to the trust's service review of palliative care services.
- Work had commenced in the development of a Commissioning for Quality and Innovation (CQUIN) framework that aimed to encourage healthcare providers to demonstrate quality improvements and innovation in relation to advanced care planning for end of life patients. One of the SPCT consultants spent one day a week focusing on developing and implementing a baseline audit. To support this work the hospital had commenced recruitment for a clinical nurse specialist on a one-year contract.

Outpatients and diagnostic imaging

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

Information about the service

The main outpatients clinic of Hammersmith Hospital was located on the ground floor with four clinic areas and 35 consulting rooms. The general outpatients area saw about 82,000 people per year (60%) of all outpatients attending the hospital, with the remainder being seen in the specialist clinical areas. The general outpatients department included a variety of specialist medical teams such as oncology, cardiology, respiratory medicine, endocrinology, gastroenterology, neurology, podiatry and diabetes. There was also a phlebotomy service.

We inspected the general outpatients, oncology and radiology departments. We spoke with 11 patients and three family members or carers. In addition, we spoke with 13 members of staff including managers, doctors, nurses, administrators and receptionists. We observed care and treatment and looked at care records. Before our inspection, we reviewed performance information from and about, the hospital.

Summary of findings

The administration of appointments for the outpatients department were leading to unnecessary delays and inconvenience to patients. The number of clinics had not increased in the last year despite an increase in patients. As a result, patients had to wait longer to get an initial appointment and also to be seen in the clinic. Managers were unable to tell us the process by which they monitored performance and made improvement plans.

Staff felt supported by their local clinical managers but did not think senior managers provided the same level of support. There was very little performance information around key areas such as how quickly initial appointment letters were sent out, how long people waited in clinics and how quickly letters were sent to GPs following an outpatient consultation.

There were enough nursing and medical staff in the department to ensure appropriate care was provided. The majority of staff had completed mandatory training, including safeguarding vulnerable adults.

Patients were treated with compassion, dignity and respect. Reception staff were polite and took time to explain things to patients and their relatives. Patients were positive about the care they received and were greeted by a 'floor walker' who ensured their specific care needs were identified and supported.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services safe?

Good

Staff identified and reported adverse clinical incidents appropriately and learnt from the outcomes of any investigations. The department was visibly clean and staff adhered to trust infection control procedures. There were enough nursing and medical staff in the department to ensure appropriate care was provided. The majority of staff had completed mandatory training, including safeguarding. Medicines were stored securely and regular medicine audits were undertaken.

Incidents

- Staff had access to the trust's online incident reporting form and were trained to use it. They said they used the reporting tool when they needed to.
- Senior staff talked us through and showed us reports of previous incidents that occurred in the department and explained the changes that had been made as a result. The main concern was about patient transport, where vulnerable patients had remained in the department following their appointment for many hours waiting for transport to take them home.

Cleanliness, infection control and hygiene

- Clinical areas were visibly clean and tidy and staff told us the clinic rooms were cleaned daily. We observed checklists and 'clean' stickers had been completed to indicate when areas had been cleaned. Toilet facilities and waiting areas were visibly clean and we found cleaning schedules had been completed.
- There were hand-washing facilities and hand gel dispensers in every consultation room and we observed staff washing their hands and using hand gel between treating patients. Weekly hand hygiene audits were undertaken by the matron and when non-compliance with hand hygiene protocols were found, feedback was provided to the individual staff members.
- We found all curtains in the department were disposable and were dated to indicate when they needed to be replaced.
- Staff we spoke with were aware of the trust's aseptic non-touch technique guidance which aimed to reduce the risk of infection. 'Bare below the elbow' policies were adhered to by staff in the clinical areas where examinations were taking place.
- Personal protective equipment such as gloves and plastic aprons were available for staff to use when appropriate.
- We found there were sharps waste bins in all clinic rooms and none were more than half full. This meant the risk of staff receiving a needle-stick injury was minimised.

Environment and equipment

- The outpatient areas were accessible to all patients, including those in wheelchairs or had other challenges with their mobility.
- There was sufficient seating in all clinics. The chairs in the waiting rooms were suitable for people who had difficulty sitting down and getting up. This reduced the risk of patient falls.
- We observed the 'floor walker' on duty at the entrance to the clinic to assist patients as necessary. The 'floor walker' greeted and supported patients as they arrived at the clinic.
- Staff told us there was adequate equipment available in all outpatient areas. Equipment was appropriately checked and was visibly clean. We noted the resuscitation equipment in the clinic had been checked daily and was regularly maintained.
- The whiteboard in Clinic D contained information for two clinics and also the phlebotomy area. The board was too small to contain this much information which made the writing on it very small and difficult for patients to understand.

Medicines

- Medicines were stored securely. We examined all seven treatment rooms and found that all medication cabinets were locked. Staff we spoke with were aware of the hospital's policy on the safe storage of medicines.
- The department undertook regular medicine audits and produced copies of the findings for us.

Outpatients and diagnostic imaging

Records

- Doctors we spoke with told us it was quite rare for them not to have a full set of patient notes. We noted all 46 medical records for four of the clinics we visited were available and no patient was due to be seen using a temporary record.
- However, patient records were not always stored securely. In Clinic D, we found notes were stored only a few inches from and within clear sight of where patients were waiting to be seen. The names on the front of some of these records could be read and records could easily have been removed by unauthorised persons. We pointed this out to the matron who confirmed new secure cabinets had been ordered in August 2014 but had not yet been delivered.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were asked for their consent before procedures were carried out. They told us staff always explained procedures to them before carrying them out. We examined 17 sets of patient notes and found that in the three of them where consent should have been recorded, there was a correct record of the patients' consent.
- Staff were clear about their responsibilities in line with the Mental Capacity Act 2005.

Safeguarding

- The department had up-to-date policies and procedures for safeguarding children and adults. This included having the contact details for identified adult and children's safeguarding leads in the trust should staff need advice or guidance.
- The outpatients matron told us the department had not had any safeguarding issues or referrals in the last 12 months. The matron was able to demonstrate the last safeguarding incident that had occurred in the department had been managed appropriately and in line with trust policies and procedures.
- Staff were clear about what action they should take should they suspect a patient was at risk or the subject of abuse.
- We noted there was safeguarding information on the walls of the clinic for staff and the public.

Mandatory training

- The trust's training records for the department showed 83% of staff had completed their mandatory training, which covered areas such as basic life support, conflict resolution, moving and handling, infection control, safeguarding, information governance and improving communication.
- Mandatory training was provided either face-to-face or online, depending on the topic. We were told cover was provided to enable staff to attend training when required.

Assessing and responding to patient risk

- Staff told us all patients who attended the clinic were seen when they arrived by the 'floor walker' who identified patients who were unwell or at risk and took appropriate action to provide any additional support as necessary.
- We observed all the 15 patients who attended the clinic during a 25-minute period were greeted by the 'floor walker', who offered them assistance and support.

Nursing staffing

- The department had undertaken a patient-needs analysis to confirm the correct number of staff it needed to care for patients. The department had an establishment of four registered nurses (one post was vacant) and 12 outpatient care assistants (two of whom were trained nursing assistants). We found the outpatients departments were adequately staffed based on the needs of the patients who attended. The department always had a senior nurse on duty, who had overall responsibility for maintaining the staffing rota and managing staffing issues to ensure clinics were appropriately staffed.
- The matron and senior nurse for outpatients were supernumerary and not included in the department's staffing numbers. They were available to supervise and assist staff as necessary.
- Each clinic also had a nurse who was responsible for making sure the patients' notes were completed, undertook initial procedures such as weighing the patient and acting as a chaperone if needed.

Medical staffing

- Staff told us every clinic was consultant-led. We found all the clinics on the day of our inspection had a consultant present although they did not see all patients.
- Staff told us there was no rota setting out which middle and junior grade medical staff were expected to attend clinics to support the consultant. However, in one clinic

the consultant was the only doctor present. This meant patients often had to wait longer to see that doctor. Overall, there were insufficient numbers of medical staff in some clinics in order to meet the increasing demand for appointments.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Clinical practice followed National Institute for Health and Care Excellence (NICE) guidelines and patients told us they were satisfied with the treatment they received in the department. There was only one pain clinic in the trust, which was based at Charing Cross Hospital and it had a long waiting list. This meant patients may not be able to access specialist pain treatment and support when they needed it.

Clinics did not operate outside of normal business hours making access more difficult for some patients who had full-time jobs.

Evidence-based care and treatment

- We were told that national guidelines such as those recommended by NICE, were followed where appropriate – for example, the care pathway for patients with diabetes. Clinical staff we spoke with demonstrated knowledge of the NICE guidelines relevant to their specialist areas.
- We observed good practice which followed established guidelines in the phlebotomy clinic.
- We found a holistic approach was used to effectively support patients with diabetes. This involved working with other partners to support patients in managing their lifestyle.

Pain relief

- Patients told us staff had spoken to them about pain control and explained they should contact their GP or the medical secretary if they experienced pain after leaving the clinic. Patients had also been informed of the special pain clinic run by the trust.
- Staff told us there was only one pain clinic in the trust at Charing Cross Hospital and it had a long waiting list. This meant patients may not be able to access specialist pain treatment and support when they needed it.

Patient outcomes

- Staff told us diagnostic test results were available promptly to support consultations. We spoke with the radiology department manager who told us the department was well-staffed and able to provide reports electronically within 48 hours, 98% of the time. This meant patients' treatments were not delayed. We found the radiology department had effective performance management information that ensured it was able to manage both quality and risk.

Competent staff

- Staff we spoke with were competent and knowledgeable about their specialist areas.
- All staff had had an annual appraisal on their performance in the last 12 months. During their appraisal, staff were asked to identify how they could develop their performance in the future.
- All newly appointed staff in the department had completed an induction programme which included mandatory training as well as an overview of trust practices and procedures.

Multidisciplinary working

- We found nursing specialists were effectively used as part of the clinical team in the podiatry and diabetic clinics.
- We found the department worked well with the local provider of NHS community care to ensure consistency of treatment for patients in the community.
- We found that, although there were many 'volunteers' who were willing to support the trust in its work, they were not used in the outpatients department.

Seven-day services

- All outpatient clinics were provided Monday to Friday between 9am and 5pm. There were no early morning or late evening clinics for people who worked during the day.
- We were told the trust wanted to provide longer hours and weekend clinics but had been unable to obtain the support from clinical staff.

Outpatients and diagnostic imaging

Are outpatient and diagnostic imaging services caring?

Good

The care delivered by staff in the outpatients department was good. Patients were positive about the care they received. Doctors, nurses and healthcare assistants treated patients with care and compassion and spoke to them in a dignified way.

Compassionate care

- Patients were treated with compassion, dignity and respect. For example, we observed reception staff being polite and taking time to explain things to patients and their relatives.
- We observed doctors, nurses and healthcare assistants speaking to patients in a dignified way; they greeted them and introduced themselves by name.
- Most patients told us their experience in the department was positive. One person said, "It's improved so much in the last two years; people have been more than helpful". Another person in the diabetic clinic told us, "People don't know how lucky they are having Hammersmith Hospital".
- Patient consultations took place in private rooms and we noted sensitive information was never discussed in public areas. Staff told us if necessary they would use a quiet room to discuss confidential matters.

Patient understanding and involvement

- Patients we spoke with stated they felt they were involved in their care. For example, they said they had been told what treatment options they had available to them and any risks or side effects had been pointed out.
- We observed that patients' families or carers could accompany them to their consultation. This allowed patients to feel more at ease and meant they had support if required.
- The department undertook its own satisfaction survey using information collected from public terminals in the department. To the question "Would you recommend this department to a friend or family member?", 88% of patients said 'yes' in July 2014. The percentage for May 2014 was 92% but in March and June 2014 it was 73% and 74% respectively.

Emotional support

- Staff told us they would support patients who had received bad news by taking them to a quiet room and giving them the time to talk about their feelings.
- Staff had been trained to identify people living with dementia and how to provide them with additional support.
- We observed a patient who was living with autism and found staff adapted their approach to make them feel more comfortable and kept reassuring them throughout their time in the clinic.

Are outpatient and diagnostic imaging services responsive?

Inadequate

Letters from the gastroenterology clinic had not been sent out to GPs since February 2014 and there was a backlog of 150 letters. The hospital had not responded to the gradual increase in attendances to the department. As a result, patients had to wait longer to get an initial appointment. Some appointment letters were also being sent out later than the trust's target of 10 days after referral.

Doctors consistently turned up late for clinics without explanation and patients were waiting too long before they were seen in the clinic. Several clinics were also cancelled by consultants at short notice. Patients did not always find it easy to contact administration staff for specialist clinics if they had a query about their appointment.

Vulnerable patients regularly remained in the department following their appointment for many hours waiting for the patient transport to take them home.

Service planning and delivery to meet the needs of local people

- Staff told us there had been a gradual increase in number of patients attending the majority of clinics. Many staff felt this increase had not been effectively managed and, as a result, patients were waiting longer to get an initial appointment and were also waiting longer in clinics to see the doctor or nurse practitioner. We noted that the capacity of the clinics had not been increased to deal with the larger number of referrals. Staff told us this was because of the limited number of doctors working in the department. Managers we spoke

with were unable to provide evidence to show how this increasing demand for outpatient services was being managed effectively or how they monitored performance.
- Managers we spoke with said there was no system for ensuring the number of doctors and specialist nurse practitioners matched the needs of the patients in any particular clinic. This resulted in longer waits for initial appointments and over-booking of clinics, which led to longer waits in clinics for patients.

Access and flow

- Most patients who attended the outpatients department were referred by their GP to the hospital. Other patients were referred from other hospitals or by other departments within the hospital. All referrals for outpatient appointments were registered by the central booking team who allocated appointments and send out appointment letters to patients.
- We were told the trust's target was to provide the patient with an appointment letter within 10 working days of receiving the GP's referral letter. Staff told us that, on average, appointment letters were being sent to patients between one and two weeks after the GP referral letter had been received. However, we found on our inspection on 5 September 2014 that all the GP referrals going back to 22 August 2014 had not yet been processed because a particular consultant had been on away on leave. The trust was unable to provide us with any information to demonstrate the department's performance in this area was monitored.
- Staff told us that most patients had appointments within nine weeks of the GP referral letter but gastroenterology could take up to 10 weeks and hepatology was more than 13 weeks.
- Staff told us if clinics were delayed, information on the expected waiting times was displayed on a whiteboard in each of the clinics. In the seven clinics we observed, we found patients were being informed by staff at regular intervals of any delays. We noted the whiteboard in the clinics was being kept up to date with the estimated delay times.
- Staff told us doctors were regularly late for clinics. The reasons for doctors' lateness were reported as due to being delayed in meetings, theatre or on ward rounds. However, as they often did not inform the clinic of these delays, staff could not inform patients.
- Staff told us most clinics usually overran by up to an hour and the longest delays of up to three hours were in the diabetic clinic. Patients told us waiting times in the clinic varied between a few minutes to more than two hours.
- While the times patients arrived and left the clinic was recorded by the receptionist, the time patients were called for their consultation was not. Therefore, it was not possible for the department to monitor or accurately report patients' waiting times or to demonstrate that capacity did not meet demand.
- The hospital performed worse than the England average for patients not attending appointments. For the financial year 2013/14, 9% of patients did not attend their outpatient appointment compared to the national average of 7%.
- The hospital cancelled 9% of the appointments which was also worse than the England average of 6%.
- On the day of our inspection we were told the hypertension clinic shown on the board had just been cancelled. Staff and managers we spoke with were not able to provide a reason for this.
- The hospital had a dedicated urgent cancer referral team who ensured all cancer referrals were managed effectively. Patients were able to see a consultant within the two-week target.
- Due to a staffing issue, all letters from the gastroenterology clinic had not been sent out to GPs since February 2014 and there was a backlog of 150 letters. This created a serious risk to patients as GPs may have been unable to progress their treatment in the community.
- The trust aimed to inform patient GPs in writing of the outcome of their consultation in the outpatients department and any ongoing treatment that was required within five working days. This was to ensure that appropriate community care and treatment could be promptly provided. During our inspection we found this target was not being met and GP letters were frequently delayed for more than 10 working days.
- Staff we spoke with, including the medical secretaries who were responsible for sending the GP's letters, were clear about the process for preparing and sending out these letters. However, some staff told us they did not feel managers monitored the department's performance of making sure GP's letters went out on time. Managers

we spoke with were unable to confirm how the department was performing against the trust's five working day target, as information had not been collected on its performance in this area.
- The respiratory clinic provided a 'one stop' service where patients could obtain an x-ray if needed, while the clinic was still operating. This meant the inconvenience to patients of having to return on another day was reduced and treatment could be provided more immediately.

Meeting people's individual needs

- Staff told us they had ready access to a translation service for those patients who did not speak English as their first language, to ensure they could fully engage in their consultation. Written information was available in different languages on request.
- All clinics had been fitted with induction loops to support people with hearing needs. We found patients who had hearing or sight needs where identified by stickers on their medical notes. This meant staff were able to provide additional support such as in ensuring effective communication with these patients.
- There was a range of written information available for patients in the outpatient waiting areas. Some of these leaflets had been produced by the trust and others by external agencies such as the Royal Colleges.
- Patients with queries about the date or time of their appointment were given a central telephone number to contact to resolve any issues. However, patients we spoke with said they sometimes had experienced issues contacting specific medical secretaries and the central booking office. These issues included long waiting times for the telephone to be answered and getting through to the correct person. They also said that, when they had left a message, their call had not been returned.
- Vulnerable patients regularly remained in the department following their appointment for many hours waiting for the patient transport to take them home.
- We found the entrance area to the clinic was far too hot. A person spending too much time in this area could have suffered the consequences of extreme heat. We pointed this out to the matron who told us she had reported the problem six months ago but it had still not been fixed by the maintenance department.

Learning from complaints and concerns

- Information on how to complain was easily available in the waiting areas.
- We were told informal complaints were managed by the outpatient matron or nurse in charge and resolved if possible at this stage. If they were unable to resolve the complaint satisfactorily, the patient or relative would be directed to the Patient Advice and Liaison Service (PALS) who would advise them about how to make a formal complaint.

Are outpatient and diagnostic imaging services well-led?

Inadequate

The trust's vision and values were not understood or fully supported by all staff in the department and some were unclear how changes at trust level affected them in their role. Staff felt supported by their local clinical managers but did not think senior managers provided the same level of support.

Non-clinical managers we spoke to did not display a good knowledge of the performance in their areas of responsibility. There was not much performance information around key areas such as how quickly initial appointment letters were sent out, how long people had to wait in clinics and how quickly letters were sent to GPs following an outpatient consultation.

There was no identified individual or group who had overall responsibility for the governance of the outpatients department, which resulted in some quality and risk issues not being managed effectively. Staff met with their local managers to discuss performance and concerns on a regular informal basis. However, managers did not arrange formal, regular and minuted staff meetings at which issues could be escalated and information disseminated to all staff.

Vision and strategy for this service

- Some staff told us it was unclear how changes at trust level affected them in their role and changes to their service were sometimes made without consultation.
- We were told by staff there had been a number of trust-wide briefing sessions about the general future direction of the trust. Most of the staff we spoke with had been to these briefings.

Outpatients and diagnostic imaging

Governance, risk management and quality measurement

- There was no identified individual or group who were had overall responsibility for the governance of the outpatients department. Responsibility was shared between staff in the clinical specialties and the outpatient management team. This resulted in some quality and risk issues not being managed effectively.
- There was an absence of quality improvement programmes or action plans relating to areas such as management of appointment letters, waiting times in clinics and communication with GPs following outpatient consultations.
- Non-clinical managers we spoke with did not demonstrate they had the requisite knowledge and understanding of governance of the department. Staff were not provided with information regarding the clinics performance and were unaware of the key performance indicators set for their clinics.
- There were no regular department meetings at which the staff from outpatients, central booking and medical secretaries met to discuss performance and other issues of common concern.
- Medical secretaries and central booking staff did not feel they had enough staff to do the amount of work they were tasked with. They told us there were too many temporary staff as the trust had stopped recruiting permanent staff.

Leadership of service

- Senior nurses in charge of the department had a clear focus of the needs of patients and the role staff needed to play. They were highly visible and respected by their colleagues.
- The outpatients department was dispersed within the structure of the hospital management. Many of the clinics were coordinated within the general outpatients department but others were managed by the clinical specialities. This meant staff were often not clear who their senior leaders were.
- Staff working in each department told us they felt able to discuss a range of issues with their line manager and felt able to contribute to the running of the department. However, they said the senior management team were not visible to department staff.

Culture within the service

- Clinic staff we spoke with were patient-focused and aimed to provide a good service for patients.
- Staff said there was an open culture in which they were encouraged by their line managers to raise and report concerns. We observed staff worked well as a team and they spoke about supporting each other and helping out as required to ensure clinics ran effectively.

Public and staff engagement

- Patients attending outpatient clinics were able to provide feedback by using touch-screen terminals available in waiting areas. This feedback was analysed, shared among staff and posted on the wall for patients to see. Although this information was collected and analysed in terms of the numbers of people who answered positively to questions, there was no detailed assessment of public satisfaction which would identify the possible areas for improvement. For example, there was no information about what it was that made people unhappy with the service.

Innovation, improvement and sustainability

- Patients attending clinics were able to use self-check-in terminals to book into clinics, which reduced the time spent waiting at the reception desk. To assist patients with this process and provide them with support there was a 'floor walker' on duty at all times.

Outstanding practice and areas for improvement

Areas for improvement

Action the hospital MUST take to improve

- Correct the high number of vacant nursing and healthcare assistant posts on the medical wards.
- Address the problems associated with the administration of outpatient appointments which was leading to unnecessary delays and inconvenience to patients.
- Reduce the significant backlog of patients who are awaiting elective surgery in the surgical department.

Action the hospital SHOULD take to improve

- Improve patient transport from the outpatients department so that patients are not waiting many hours to be taken home.
- Improve the management of medicines on the medical wards.
- Ensure patients' records are always appropriately completed.
- Ensure learning from investigations of patient falls and pressure ulcers is proactively shared trust-wide.
- Ensure cleaning of equipment is always carried out.
- Improve access to the one pain clinic that is available in the trust.
- Reduce the high number of out-of-hours transfers and discharges.
- Monitor the clinical impact of cancellations and delays in surgery.
- Ensure that surgical patients are not cared for in inappropriate areas such as in the theatre overnight.
- Improve the responsiveness of the outpatients department with regards to clearing the backlog of GP letters from the gastroenterology clinic and reducing the waiting times for patients to get an initial appointment.
- Avoid cancelling outpatient clinics at short notice.
- Ensure there is accurate performance information from the outpatients department.
- Ensure that quality and risk issues in the outpatients department are managed effectively.
- Consider reviewing the processes for the capturing of information to help the service to better understand and to measure its overall clinical effectiveness.
- Consider reviewing the current arrangements for the provision of children's outpatient services to ensure there is parity across the hospital campus.
- Consider reviewing the operating times of the David Harvey Unit to ensure the service is accessible to the local population to which it serves, at the right time of day.

This section is primarily information for the provider

Compliance actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because there were not sufficient numbers of nursing staff and healthcare assistants on the medical wards.** Regulation 22

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because the problems associated with the administration of appointments for the outpatients department were leading to unnecessary delays and inconvenience to patients.** Regulation 9 (1) (a)(b)(i)

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	Regulation 9 HSCA 2008 (Regulated Activities) Regulations 2010 Care and welfare of people who use services **People who use services were not protected against the risks of care or treatment that is inappropriate or unsafe because there was a significant backlog of patients who were awaiting elective surgery in the surgical department.**

This section is primarily information for the provider

Compliance actions

Regulation 9 (1) (a)(b)(i)