London North West Healthcare NHS Trust

Northwick Park Hospital

Quality Report

Northwick Park Hospital
Watford Road
Harrow
Middlesex
HA1 3UJ
Tel: 020 8864 3232
Website: www.lnwh.nhs.uk

Date of inspection visit: 19-23 October 2015;
unannounced visits between 3-7 November 2015
Date of publication: 21/06/2016

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

Summary of findings

Letter from the Chief Inspector of Hospitals

Northwick Park Hospital is in the London Borough of Harrow. It is part of the London North West Healthcare NHS Trust whichis one of the largest integrated care trusts in the country, bringing together hospital and community services across Brent, Ealing and Harrow. Established on 1 October 2014 from the merger of North West London NHS Trust and Ealing Hospitals NHS Trust, and employing more than 8,000 staff it serves a diverse population of approximately 850,000.

The trust runs Northwick Park Hospital, St Mark's Hospital, Harrow; Central Middlesex Hospital in Park Royal and Ealing Hospital in Southall. It also runs 4 community hospitals – Clayponds Rehabilitation Hospital, Meadow House Hospital, Denham unit and Willesden Centre - in addition to providing community health services in the London Boroughs of Brent, Ealing and Harrow.

At the end of the financial year 2014-15 the trust had a deficit of £55.9 million.

We carried out this inspection as part of our comprehensive acute hospital inspection programme for combined acute hospital and community health based trusts. We inspected Northwick Park Hospital, Ealing Hospital and the following community health services: community services for adults; community services for children, young people and families; community inpatient services; community services for end of life care and community dental services.

The announced part of the inspection took place between 19-23 October 2015 and there were further unannounced inspections which took place between 3-7 November 2015.

Overall we ratedNorthwick Park Hospitalas requires improvement. We rated end of life care as good.We rated the followingservices as requires improvement: Urgent and emergency care, medical care including care of the elderly, surgery, critical care, maternity and gynaecology, acute services for children,and outpatients and diagnostic imaging.

Overall we rated caring at thehospital as good but safety, effective, responsive and well-led as requires improvement.

Our key findings were as follows:

- The merger of the trust had been protracted and subject to delay. This had had a negative effect on performance and leadership.
- We saw overall disappointing progress in merging systems and processes at the trust. To most intents and purposes Ealing and Northwick Park appeared to be operating as separate entities and community health services appeared disengaged from the rest of the trust.
- There appeared to be substantial duplication of support functions at both main sites. There appeared to have been lack of control over spend of administrative, non-staff, and nursing staffing budgets with little rationale over nursing numbers on wards.
- A new chief executive had recently been appointed earlier in 2015. She was in the process of building a new executive team and by the time of our inspection only one member of the previous substantive executive team was in post. This meant that the new executive team were in the process of getting to grips with their respective functions.
  - All staff working at the hospital were dedicated, caring and supportive of each other within their ward and locality. There was a high degree of anxiety and uncertainty borne out of the merger.
  - There appeared to be a lack of firm information provided to staff about the effects of Shaping a Healthier Future - to reconfigure services in north west London - despite the chief executive holding regular briefing session. This added to staff anxieties.
  - We saw several areas of good practice or progress including:
  - a newly opened emergency department at Northwick Park

Summary of findings

- a refurbished and child friendly ward for children's care called Jack's Place.
- caring attitudes, dedication and good multi-disciplinary teamwork of clinical staff.
- good partnership working between urgent and emergency care staff and London Ambulance staff.
- good induction training for junior doctors.
- research projects into falls bundles, stroke trials and good cross site working in research.
- Staff told us there were good opportunities for training and career development.
- We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner.
- The play specialists in services for children demonstrated how they could make a difference to the service and its environment in meeting the needs of the children and young people. This includedan outstanding diversional therapy approach for children and young people, which was led by the play specialist and school tutor.

However, there were also areas of poor practice where the trust needs to make improvements:

- There was limited sparse medical cover on eHDU out of hours and at weekends, which meant there was frequently no doctor immediately available on the unit. Consultants responsible for eHDU and Dryden HDU were not intensivists and processes for escalating surgical patients were unclear. Additionally, less than the recommended proportion of eHDU nurses had critical care qualifications.
- There was a lack of expert support from consultant radiologists at weekends, which impacted on the accuracy of clinical diagnosis being achieved. Risks related to patient safety and service delivery had not always been identified and agreed timelines for resolution had not always been identified. Thisled to scans being reported by specialist registrars (SpR's) and amended by consultants on Mondays. They reported an apparent 25% amendment rate, with missed pathologies.
- Surgical staff were not always reporting incidents. Consultants and other surgical staff told us they did not routinely complete incident reports for issues or concerns as the forms were said to be "too laborious" and nothing was done to change the problems highlighted.
- Access to services and patient flow through the ED at Northwick Park to wards in the hospital was poor and patients experienced long waits in the HDU and assessment unit areas.
- The performance dashboards for ED showed that compliance with achieving the mandatory targets, including the 4 hour treatment target, had been poor over the previous 12 months.
- The emergency department participated and performed poorly in the College of Emergency Medicine audits on pain relief, renal colic, fractured neck of femur and consultant sign-off; and there were no clear action plans drawn up by the department indicating what actions were taken as a result of the audits.
- Compliance with safeguarding training was poor particularly among medical and dental staff.
- The trust target was to have 95% of staff having completed mandatory training. Trust data, as of March 2014 – July 2015, showed compliance with the target was poor in many areas.
- We saw examples of poor infection control practice such as linen left on a bin when a nurse was putting gloves on, staff wearing nose rings and hooped earrings that were not covered and name badges that were made of paper.
- There was a poor environment on the stroke wards at Northwick Park Hospital.
- There were poor handovers between ED and the wards at Northwick Park with MRSA screening and medicines management not always clear or complete in the handovers.
- Nutrition and hydration was poorly managed on Northwick Park medical wards with poor assessments, choice of food and support for those that needed it.
- In surgery, several groups of patients had no formally defined pathway, which impacted on their safety.
- The National Bowel Cancer Audit for 2014 indicated that data completeness for patients having major surgery was poor at 30%, compared with an England average of 87%.
- There was a lack of formal escalation process for surgical patients who deteriorated on eHDU aside from the support provided by the outreach team.

Summary of findings

- Handovers to the consultant taking over care of eHDU patients on a Monday morning was completed by the weekend on call anaesthetic registrar rather than a consultant to consultant handover. Staff highlighted this as a concern as there wasarisk important information could be missed.
- In maternity and gynaecology, there were safety concernsrelated to midwife shortages, not having safety thermometers on display and some staff reporting that they did not get feedback after reporting incidents.Staff raised concerns about one midwife covering the triage and observation areas at same time during times of pressure.
- We were concerned that some of the risks we identified were not on the risk register, such as the room used for bereaved women on the delivery suite at Northwick Park Hospital with a lack of sound proofing from the ward.
- Staff on wards outside of the end of life team had a poor understanding of end of life care and the trust LDLCA - Last days of life care agreement. Concern was raised that doctors and nurses on the wards did not recognise deteriorating and dying patients.
- Signage for outpatient clinics was in some cases poor and or stopped short of providing clear directions for patients.
- In outpatients and diagnostic imaging, poor patient experience was due to overbooking clinics, lack of capacity in outpatients and lack of availability of medical records in time for clinics.
- In OPD, we were concerned incidents were not always appropriately recognised, escalated or investigated and lessons learned were not widely shared
- The pre-inspection information identified some concerns around consultant cover in haematology. Some of the facilities were not suitable to meet the needs of patients, for example, the haematology day care service.
- Audits showed hand hygiene was a concern with some wards either not submitting audits or scoring less than 90%.
- We had concerns with medicines given by night staff. Drug rounds were arranged so night staff had a round at the start and two at the end of their shift with a potential increased risk of error.
- All types of therapy visits on wards were unscheduled meaning patients could miss their therapy if they were away from their bed or in pain.
- Trust wide there weretemperature control issues across sites in rooms where medicines are stored.
- The above list is not exhaustive and the trust should address these and the rest of the issues outlined in our reports in its action plan.

Importantly, the trust must:

- provide expert support from consultant radiologists at weekends.
- ensure effective processes for reporting, investigating and learning from incidents, and ensure all staff always report incidents.
- provide sufficient trained and experienced medical and nursing cover on eHDU at all times including out of hours and at weekends to ensure immediate availability on the unit.
- Weissued the trust with a Section 29 (A) warning notice in relation to the three " must do" items listed immediately above requiring substantial improvements.
- The above list is exhaustive and the trust must pay attention to remedy all other issues raised in the report.

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?
Urgent and emergency services	Requires improvement 	Theemergency department (ED) had not achieved the four-hour national target of 95% of all patients seen within four hours from July 2014 to June 2015, an average of 90% of patients were seen within the four-hour target time. Patients often waited for long periods before staff moved them to an appropriate ward or department once a decision to admit hadbeen made. Access to services and patient flow through the ED to wards in the hospital was poor and patients experienced long waits in the HDU and assessment unit areas. The physical layout of the department and waiting times for admission and discharge to or from the EDordid not ensure the safety of patients in the department. The leadership team within the department demonstrated innovation, and encouraged learning and listening across all grades of staff. There was a clear local management structure in the department. However, the senior management within the trust did not appear to be working closely together to meet the strategic objectives of the department. The department had a caring and committed team of staff with a strong team ethos. Patients and relatives were all positive about the care they had received. Staff offered care that was kind, respectful and considerate. They responded to patients' anxiety or distress with compassion and offered emotional support. However, due to the open nature of the area in which the ambulance crew handover of patients took place, those in the department and adjacent corridor could overhear patients' confidential information being handed over by the ambulance crew. There was therefore limited privacy and dignity provided in this part of the patient experience.
Medical care (including older people's care)	Requires improvement 	Medical services at NPH required improvement across all key questions other than caring which we

Summary of findings

rated as good. The biggest concerns were the flow of patients through the medical wards, staffing levels, nutrition and the environment's safety and responsiveness to patient needs.
Governance and leadership also required improvement. Although there was some risk awareness and a strategy going forward, cross site working was in its infancy and performance was not fully monitored.
Other areas of concern including patient record completion, mandatory and competency based training. A number of areas of where understanding and performance was limited or variable included adherence to the Mental Capacity Act or engagement with staff and the public.
However, most of the patient feedback we received was positive including involvement in care and privacy and dignity. Patients who deteriorated or were in pain were well managed and patient harm was being actively reduced. Complaints were responded to and acted upon.
There was a supportive leadership at ward and department level but there was an impression the divisional leadership were acute pathway focused. There were also some unclear reporting lines in care of the elderly.

Surgery **Requires improvement**

The reporting of incidents was not fully embedded in practice across all staff groups. Incident type was not always categorised correctly and there was a lack of awareness of outcomes from incident investigations , including never events.
There was a lack of expert support from consultant radiologists at weekends, which impacted on the accuracy of clinical diagnosis being achieved. Risks related to patient safety and service delivery had not always been identified and agreed timelines for resolution had not always been identified.
There was a lack of formalised admissions pathways for some surgical patients, including those with head injuries. The surgical wards had not been developed to address the needs of individuals living with dementia.
Patient surgical outcomes were monitored through audit and required improvements had been noted for hip fracture patients and those having an emergency laparotomy. Referral to treatment times

Summary of findings

were not being met in some surgical specialties.
Theatres were not always effectively utilised and operating sessions started and finished later than planned, which impacted on patient discharges.
There was lack of assurance that staff had received Mental Capacity or Deprivation of Liberty Safeguard training.
Surgical staff reported a lack of support and engagement at trust board level.
The development of the surgical directorate strategic aims was in progress and would need time to be embedded into practice.
There had been limited opportunities for patients to contribute to the running of the surgical service, although they were able to feed back on their experiences.
Surgical directorate leaders understood their roles and responsibilities and the governance arrangements were set out to facilitate the monitoring of identified risks, reported safety concerns, patient outcomes and effectiveness of the service.
Staff demonstrated a commitment to delivering high standards across the surgical service and there was a culture of openness and transparency. The ward and theatre staff reported favourably on their immediate line managers, their approachability and support and felt valued and respected
Staff had the necessary skills and experience to ensure safe and effective patient outcomes and were supported appropriately.
Patients needs were assessed, treated and cared for in line with professional guidance, under the leadership of consultants. The multidisciplinary team and specialists supported the delivery of treatment and care. Patients reported positively with regard to the quality and standards of care they received from staff.
Where complaints were raised, these were investigated and responded to and where improvements were identified, these were communicated to staff.

Critical care **Requires improvement**

The critical care service requires improvement.
Medical staffing on eHDU was not sufficient and care was provided by anaesthetists without critical care accreditation. Additionally, less than the

recommended proportion of eHDU nurses had critical care qualifications. The provision of pharmacy staff within critical care did not meet recommended standards and multi-disciplinary working was variable across the service. There was little shared learning across the service or with other specialities within the hospital and a limited relationship with the critical care team at Ealing Hospital.

The critical care environments were not compliant with HBN0402 building notes and compliance with infection prevention and control measures was variable. Patient outcomes were not as good as those at similar units nationally and other local units. There was a high occupancy rate throughout critical care and there had been some elective surgery cancelled as a result of this. There were significant numbers of non-clinical transfers as well as out of hours discharges as a result of critical care bed shortfalls. Senior staff were aware of these issues and had sent reports with relevant data to the senior management team,however no steps were in place to address the shortfall in critical care beds.

There was a positive culture across critical care and a good clinical leadership presence. Managers within the service were aware of the risks on the individual units and these concerns were reflected on the relevant departmental risk register. There was an obvious desire to improve the quality of care delivered. Results from the Friends and Family Test and our Short Observational Framework for Inspection (SOFI) were positive and we received complimentary feedback from patients and relatives throughout the service. The service respondedto any negative feedback from patients and their visitors proactively.

Maternity and gynaecology — **Requires improvement**

We found concerns regarding the safety arrangements in the maternity services.These related to midwife shortages, not having safety thermometers on display and some staff reporting that they did not get feedback after reporting incidents.

Staff shared concerns with us about the environment, temperature and faulty equipment in the Day Assessment Unit.(DAU).

Summary of findings

The records we reviewed showed venous thromboembolism (VTE) assessments were carried out and maternity early warning score (EWS) assessments were being completed. Gynaecology was also completing EWS. There were up-to-date evidence-based guidelines in place, however we were not able to find evidence that 'Fresh eye' checks were being recorded every hour for women during labour.

We did observe good practice in terms of effective multidisciplinary team working, multidisciplinary handover on delivery suite and that staff had the right skills, qualifications and knowledge for their role.

Some women experiencing pregnancy loss were being cared for in a room without sound-proofing. This meant that women in the room could hear the sounds of babies crying and this could cause distress. However, people told us they were consistently treated with dignity, kindness, and respect throughout the services.

We requested the current percentages of women seen in the labour ward within 30 minutes by a midwife, and the percentage seen by a consultant within 60 minutes, to determine timeliness of assessment. This information however was not being recorded.

Most of the people using the service told us that did not know who to make a complaint. Between October 2014 to September 2015 the service received 64 complaints. 13 of these were still open and being investigated at the time of the inspection. Some complaints had been open for over two months.

The Trust had a clear vision and strategy however the staff we spoke with did not demonstrate awareness or understanding of it. The trust vision and strategy was not visible throughout the wards and corridors. We saw the services' business plan for 2015 – 2016. It did not include the vision of the service.

Services for children and young people

Requires improvement

Children and young people's services at this trust were rated as requires improvement except for caring which was good. The safeguarding children's procedures were robust with staff demonstrating how they were embedded into the service.

Summary of findings

We saw out of date policies in use and Control of Substances Hazardous to Health (COSHH) assessments not reviewed in line with policy changes implemented.
Staff shortages meant that staff hadto workextra shifts.
Senior staff had to physically seek out when children were admitted to an adult bed, as there was no flagging system. There were gaps in support arrangements for children with long term conditions e.g. epilepsy and no identified nurse specialist to support this group of patients who required information and support.
The service was not responsive in meeting the needs of children and young people when in the children's accident and emergency department, as the waiting time was reported as too long by parents we spoke with.
Staff who wereasked about the trust strategy were not all aware of local or trust wide strategies.
The arrangements for governance and performance management did not always work effectively, as items on the risk register did not reflect all the areas that require improvement identified by the inspectors e.g. COSHH.
We raised concerns about the lack of neonatal resuscitation equipment and resuscitaire in the accident and emergency department.
The service had achieved 93% of children being seen within 18 weeks of referral for treatment with 7% of patients breached over 18 weeks which did not meet the target.
Feedback from family members and children or young people we spoke with was positive about the care provided. Parents said that staff went the extra mile for their children and staff engaged children and parents in individualised plans of care.
Services were planned and delivered to meet the needs of the diverse population.

End of life care

Good

We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner.
The patients and relatives spoke positively about their interactions with the teams involved in their care.

Summary of findings

The trust had responded to the withdrawal of the Liverpool Care Pathway. The trust used a holistic document which was in line with the five priorities of care, was called the 'Last Days of Life Care Agreement' (LDLCA). However, this document was not compulsory to use across the hospital leading to difficulties in following some care plans.
Patients' records and care plans were regularly updated, matched the needs of the patient and were relevant to EOLC.
There were some concerns raised by specialist staff and from our observations about whether all generalist nurses, doctors and consultants had the expertise to recognise dying; and had the skills to have difficult conversations about planning care for those at the end of their life.
The SPCT were focussed on raising staff awareness around EOLC. However they said that this should be a trust wide responsibility.
The trust had recently run a pilot training scheme for staff on the elderly care wards. However this is not yet part of mandatory training.
Staff were aware of their responsibility in raising concerns and reporting incidents.They were keen to report any incidents in relation to palliative and EOLC in order to drive improvement.
There were few complaints in relation to EOLC and staff told us they preferred to deal with concerns or issues at the time to try to deal with it prior to it becoming a formal complaint.All staff understood their role and responsibility to raise any safeguarding concerns.
We found that leadership of the SPCT was good at a local level, and all staff reported being supported by their line managers. The SPCT were able to communicate the trust's vision. However they were not always able to explain how this was going to be met. Cross site working was in its infancy and staff expressed a difficulty in doing more due to the difficulties in physically getting between the hospitals in the trust.

Outpatients and diagnostic imaging

Good

Outpatients and diagnostic imagingservices at Northwick Park Hospital did not consistently offer appointments within defined target times.
There was a system in place to highlight which patients had waited longest and should be

Summary of findings

prioritised for the first available appointments. The trust had attempted to reduce the backlog of patients waiting for appointments, but financial constraints meant that additional clinics had been stopped.

We found that management of risks associated with emergency situations in some areas within the outpatient services including haematology had not been appropriately recognised, assessed or managed.

We found that there were regular shortages of nursing staff of up to 20% in the outpatients departments.

We found the method for tracking medical records was not reliable. Notes were stored in the medical records department and were collected by medical records staff in preparation for outpatient clinics.

Staff were not always aware of or have access to the incident reporting system through Datix.

We found limited evidence of the effectiveness of outpatient services and at times staff were not always caring or respectful of patients.

The services had begun to integrate across the three hospital sites following the merger in 2014, but there was more work needed.

We saw good evidence of how diagnostic services respond to patients' needs and how outpatients track the progress of patients on the waiting lists for appointments.

Northwick Park Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Northwick Park Hospital

Northwick Park Hospital is part of London North West Healthcare NHS Trust, whichis one of the largest integrated care trusts in the country, bringing together hospital and community services across Brent, Ealing and Harrow. Established on 1 October 2014 from the merger of North West London NHS Trust and Ealing Hospitals NHS Trust, and employing more than 8,000 staff it serves a diverse population of approximately 850,000.

The trust runs Northwick Park Hospital, St Mark's Hospital, Harrow; Central Middlesex Hospital in Park Royal and Ealing Hospital in Southall. It also runs 4 community hospitals – Clayponds Rehabilitation Hospital, Meadow House Hospital, Denham unit and Willesden Centre - in addition to providing community health services in the London Boroughs of Brent, Ealing and Harrow.

The hospital andtrust currently do not have foundation trust status.

Thehospital serves an ethnically diverse population mainly concentrated in the London Borough of Harrow. The health of people in Harrow is generally better than the England average. Deprivation is lower than average, however about 17.0% (8,000) children live in poverty. It ranks 194th most deprived of 326 local authorities in the country. Life expectancy for both men and women is higher than the England average in Harrow.

Services provided: Northwick Park Hospital provides the following inpatient services: gastroenterology, urology, vascular surgery, gynaecology, trauma and orthopaedics, maxilla-facial surgery, general medicine, critical care medicine, cardiology, infectious disease treatment, urgent and emergency care, paediatrics, neonatology, obstetrics, geriatric medicine, stroke medicine, respiratory medicine, rehabilitation and paediatric intensive care.

The hospital provides outpatient services including: audiological medicine, bowel screening, breast surgery, cardiology, dermatology, diabetic medicine, dietetics, ear nose and throat medicine (ENT), gastroenterology, geriatric medicine, gynaecology, haematology, infectious diseases, medical oncology, neonatology, obstetrics, maxillo-facial surgery, orthodontics, paediatric clinics, rheumatology, trauma and orthopaedics, urology and vascular surgery.

Number of inpatient beds:687

Between August 2014 and July 2015 there were three never events at the previous trust which included Northwick Park Hospital, and 207 serious incidents.

There were 48 cases of C Diff, 5 cases of MRSA and 25 cases of MSSA in this Hospital between August 2014 and July 2015.

Between April 2013 and March 2014, the hospital received 784 complaints.

This inspection was part of our planned comprehensive inspection programme and we inspected all core services at Northwick Park.

Detailed findings

Our inspection team

Our inspection team was led by:

Chair: Dr Richard Quirk, Medical Director Sussex Community NHS Trust.

Head of Hospital Inspection: Robert Throw and Nicola Wise (observing) CQC.

The inspection team consisted of CQC managers and inspectors plus specialist clinical and non-clinical advisers including: senior NHS manager, A&E doctor, A&E nurse, critical care doctor, child safeguarding nurse, end of life care nurse, maternity doctor, midwife, general medicine doctor, general medicine nurse, outpatients doctor, outpatients nurse, paediatric doctor, paediatric nurse, surgery doctor, adult community nurse, community midwife, chiropodist/podiatrist, adult community doctor, adult physiotherapist, surgery nurse, occupational therapist, junior doctor, student nurse, community children's nurse, sexual health therapist, experts by experience/patient representatives.

How we carried out this inspection

To get to the heart of patients' experience of care in this acute hospital and community health setting we always as the following five questions of every service and provider:

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

Prior to the announced inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the trust. These included local clinical commissioning groups, NHS England, Health Education England, NHS Trust Development Authority (now NHS improvement), General Medical Council, the Nursing and Midwifery Council, Royal Colleges and local Healthwatch.

We held a public listening event with the intention of listening to the views of patients, their families and carers as well as members of the public about the services provided by the trust.

We spoke with patients and their families and carers and members of staff from all the ward and community health areas. We reviewed records of personal care and treatment as well as trust policies and guidelines. We held focus groups of different clinical and non-clinical staff grades to gain their views. Similarly we held a focus group for black and ethnic minority staff.

In addition to the announced inspection which took place between 19 - 23 October 2015, we carried out unannounced visits between 3 - 7 November 2015.

Facts and data about Northwick Park Hospital

Safe:

Serious incidents: 207 were for Northwick Park between Aug 2014 and Jul 2015.

At Northwick Park, the proportion of junior doctors and consultants is similar to the England average.

Infection rates for C. diff and MSSA have been higher since the trust merger. MRSA rates were variable between 0 and 2 in any given month with no discernible trends.

There were four never events in the trustreported between August 2014 and July 2015. 3 werein Northwick Park(Medicine x2 and Surgery x1).Never events details: Medicine: Aug 2014 (2014/28410) – misplace NG tube, patient died. May 2015 (2015/17992) – transfusion incident, wrong blood given. Surgery: Dec 2014 (2014/41155) – wrong site surgery, on finger.

NRLS incidents: There were fewer NRLS incidents per 100 admissions than the England average for the same period.

Detailed findings

Bank and agency staff levels are more than double the England average.

The CQC intelligence monitoring report for May 2015 showed elevated risks for:

- Nursing staff (low) in proportion to occupied beds (Jan to Dec 14)

- Other clinical staff (low) in proportion to occupied beds (Jan to Dec 14).

Effective:

With regard toHSMR mortality, the CQC Hospital IM report ofMay 2015 showed no evidence of elevated risk.

Caring:

Prior to the merger both former trusts' performance in the Friends and Family Test was consistently below the England average. It has subsequently improved to a level above the England Average.

In the Cancer Patient Experience Survey the Trust was in the bottom 20% of trusts for 16 out of 34 indicators.

Patient Led Assessments of the Care Environment: There was a mixed performance compared with the England average for all four measures. There was an elevated risk for food (Jan to Jun 14) in CQC's Hospital Intelligent Monitoring (IM) report May 2015. (This appeared to relate to Ealing, where 2014 Privacy, dignity and wellbeing score had also fallen).

The Trust scored "about the same" as other trusts in 7 and were in the "worst performing trusts" in 5 indicators in the 2014 in-patient survey.

Responsive:

In CQC's Hospital Intelligent Monitoring report for May 2015, the Trust flagged as an elevated risk indicator for A&E waiting times more than 4 hours (Oct to Dec 14).

Well-led

The sickness absence rates at Northwick Park have been very similar to the England average.

There was mixed performance in the NHS Staff Survey 2015, with 4 positive and 7 negative findings. 19 findings were within expectation for a trust of this size.

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Medical care	Requires improvement	Inadequate	Good	Requires improvement	Requires improvement	Requires improvement
Surgery	Inadequate	Good	Good	Requires improvement	Requires improvement	Requires improvement
Critical care	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Services for children and young people	Requires improvement	Requires improvement	Good	Good	Good	Requires improvement
End of life care	Good	Requires improvement	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Requires improvement	Good	Good	Good	Good
Overall	Requires improvement	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Northwick Park Hospital is open 24 hours a day, seven days a week, seeing108, 393 patients in 2014/2015. Staff in the ED treated people with serious and life-threatening emergencies, as well as those with minor injuries requiring prompt attention.

The department had a single point of access reception in conjunction with the Urgent Care Centre (UCC) for patientswalking in to the department. Receptionist staff directed patients to the UCC or ED nurse to be triaged. The UCC or ED nurse then sent them to the appropriate area of the ED, where the ED clinical staff could see and treat them. Patients arriving at the ED in an ambulance were taken to the ambulance reception area, known as the "Pit Stop", for initial assessment before staff transferred them to the appropriate area.

We spoke with approximately 35 patients and their relatives and reviewed 22patient records during the inspection.

We visited all areas of the department, including resuscitation (resus), majors (here called the High Dependency Unit (HDU)), minors (here called the Assessment Unit) and the paediatric unit. A separate ambulatory care service was available for certain patients being referred on to secondary care by their GP.

Summary of findings

The ED had not achieved the four-hour national target of 95% of all patients seen within four hours from July 2014 to June 2015, an average of 90% of patients were seen within the four-hour target time. Patients often waited for long periods before staff moved them to an appropriate ward or department once a decision to admit hadbeen made. Access to services and patient flow through the ED to wards in the hospital was poor and patients experienced long waits in the HDU and assessment unit areas.

The physical layout of the department and waiting times for admission and discharge to or from the EDordid not ensure the safety of patients in the department.

The leadership team within the department demonstrated innovation, and encouraged learning and listening across all grades of staff. There was a clear local management structure in the department. However, the senior management within the trust did not appear to be working closely together to meet the strategic objectives of the department.

The matron designated a senior member of the nursing staff as a shift co-ordinator (helicopter). The matron did not count the shift co-ordinator as part of the nursing staff, as their role focussedonthe supervision, demands and flow of the department.

The department had a caring and committed team of staff with a strong team ethos. Patients and relatives

were all positive about the care they had received. Staff offered care that was kind, respectful and considerate. They responded to patients' anxiety or distress with compassion and offered emotional support. However, due to the open nature of the area in which the ambulance crew handover of patients took place, those in the department and adjacent corridor could overhear patients' confidential information being handed over by the ambulance crew. There was therefore limited privacy and dignity provided in this part of the patient experience.

Are urgent and emergency services safe?

Requires improvement

There was evidence that the department reported incidents. However, we were concerned that lessons learnt were not always embedded into practice. There was no information displayed to advice patients on what to do should their condition deteriorates. We noted that the assessment area was small and overcrowded, with patients standing in this area as well as the adjacent corridor(s).

The waiting area for patient waiting for further investigation, treatment and decision was small and did not have an appropriate environmental risk assessment, this area provided risks patients receiving care and treatment.

We saw that staffing levels were not sufficient in the children's ED to provide safe care. However, other nursing staffing levels were set to meet patients' needs at all times. The senior nurse told us a review of nurse staffing levels had not been completed in the last six months. There were efficient and well managed processes in place for nursing shift change handovers. The hospital had an up-to-date major incident plan that listed key risks that potentially could affect the provision of care and treatment being provided in the ED.

Incidents

- Nursing staff reported Incidents using the Datix incident reporting system, which provided a tracking mechanism for staff to check on the status of their submission. Incidents that had occurred in the department were investigated and areas for learning were communicated to staff at team meetings. The staff we spoke with told us they knew the type of incidents needed to be reported and how these would be recorded. Nursing staff told us development team days were used to discuss incidents and learning from them.
- However, the ED onlyreported three serious incidentsto the National Reporting Learning System in 2014/15. Thereported incidents included one unexpected death

(2015/15977). The ED hadreported and recorded 570 incidents of patients attending withpressure ulcers, and 26 falls with minor or moderateharm from August 2014 – July 2015.

- The ED held monthly Mortality and Morbidity (M&M) meetings led by a senior ED consultant as part of the department's internal governance arrangements. The ED participated in the trust wide clinical governance meetings held six monthly, the department did not have its own clinical governance committee meetings to discuss incidents, and ED incidents were discussed as part of the M&M meeting.
- The department did not have a dedicated security guard; the trust security guards were rotated or assigned to the department on the basis on needs. The security staff told us they were not trained in dealing with violence and aggression.
- Most of the nursing staff we spoke with were not fully aware of the new statutory 'duty of candour' although some doctors were aware of it. The duty of candour was introduced for NHS bodies in England in November 2014. Certain key principles are set out, including a general duty to act in an open, honest and transparent way in relation to care provided to patients, and as soon as is reasonably practicable after apatient safety incident occurs. Theorganisation must tell the patient (or their representative) about it and apologise in person.

Cleanliness, infection control and hygiene

- Most of the clinical areas we visited were visibly clean, and all the waiting areas and toilet facilities were clean.
- Cleaning schedules and records were available in all areas of the department and clinical staff told us that cleaners were available throughout the day to clean if necessary.
- Personal protective equipment (PPE), such as gloves and aprons were available for staff use in all areas where it was necessary. We saw clinical staff using personal protective equipment, were bare below the elbow, and washed their hands when attending to patients and in-between patients. Hand-washing facilities and hand cleaning gels were available throughout the department.
- The ED conducted infection control audits to determine compliance with infection control guidance from the World Health Organization. Audits showed hand hygiene scored over 98% compliance. The ED had infection control link nurses who acted as a resource to staff, and staff had access to infection control policies and procedures via the trust intranet.

Environment and equipment

- A new ED was built and adjacent areas refurbished in November 2014. The major's area, known as the High Dependency Unit (HDU), had 16 enclosed cubicles, the majority of which were not visible to the nurses or the doctors when seated at the nurse's stations. Direct observation was further limited because of the location of the cubicles; however, there were nurses assigned to cubicles to mitigate this. There was a central monitoring, observation and working area in the HDU. There were 26 cubicles in the assessment area.
- The resuscitation area had seven cubicles with all the necessary equipment. Staff and patients appreciated the new facilities, which provided a better and more suitable environment for emergency care than the previous department. Nurses checked resuscitation trolleys in other areas of the ED daily and were easily accessible.
- The department had a wide range of specialist equipment, which was clean and well maintained. Cleaning staff placed labels on cleaned equipment to show the equipment was cleaned. Staff told us that they checked equipment daily and we observed this in practice. Where equipment was found to be defective, this was noted and reported to the nurse in charge for action.
- The rapid assessment area was located within the assessment unit. The area lacked the space for the volume of patients seen there and most of the nursing and medical staff told us that crowding of the area was a concern. We saw the area overcrowded during busy times, and we observed patients standing on the corridors or in the waiting room waiting for decision by the doctors.
- Having found potential ligature points in the mental health place of safety room at Ealing ED,we have asked the trust to review all of the equivalent facilities at its remaining locations including those we did not inspect on this occasion.

Medicines

- The department used a computerised medication administration system (Omnicell), which was accessed by staff using their fingerprint.
- Controlled drugs were stored and administered safely by two qualified nurses. We checked the stock of controlled drugs in HDU (majors) and the resuscitation area and noted the stock balances to be correct, and CD checks were completed twice daily by two nurses.
- The temperature of the medicines fridge in the department was monitored electronically through the computerised medication administration system and we did not find any evidence that the fridge was operated with temperatures out of range.
- We observed nursing staff administered drugs and intravenous fluids safely and nurses correctly recorded drug administration on the patient medication chart. Any unused drugs were disposed of in accordance with hospital policy.
- Nursing staff told us there were medicine management policies for reference purposes. Medicine administration records we looked at were completed appropriately. The pharmacy team was actively involved in all aspects of a patient's individual medicine requirements and the team provided training and support to staff on medicines management.

Records

- We looked at the care records of 22 patients during the inspection to check if the department was routinely conducting falls risk assessments, safeguarding assessment, mental capacity assessments, Methicillin Resistant Staphylococcus Aureus (MRSA) screening, pain assessment and administration of pain relief. We found most of the records were not fully completed. Five sets of patient notes did not have the required risk assessments undertaken in the department. For example, MRSA screening and prevention of pressure damage were not recorded and others lacked assessments of pressure ulcers for patients. Nine sets of notes did not have completed observations taken with regular re-assessments recorded.
- Three patients we spoke with were at risk of pressure ulcer development. Each of them had been in the department lying on an emergency trolley for more than four hours. Staff had assessed their risks visually through experience and decided that a pressure relieving mattress should be used.
- Nursing staff told us patients who stayed for longer periods did not had detailed pressure risk assessments made at the ED until they were admitted to ward areas. The clinical record was limited in details such as the care plan to prevent deterioration of skin integrity and risk assessments not completed for patients who were on trolleys for more than four hours.
- Nurses told us assessment record had prompts for key elements of patient assessment, such as checking for the risk of venous thromboembolism (VTE). Out of 22 patients records reviewed, eight of the patients records reviewed confirmed that VTE assessments were completed.
- During our inspection, we observed that patients' information was difficult to find within the documentation because notes were not defined between clinical observations, nursing and medical notes. All entries were kept together as one and some nurses said it took time to find relevant information straight away in the notes.

Safeguarding

- Policies were in place that outlined the trust's position on safeguarding vulnerable adults and children. A safeguarding link nurse worked in the department to ensure patients who were at risk were flagged up and appropriate safeguarding referral made on their behalf. Compliance with safeguarding training was poor. Only 14%medicalstaff and 24 % of nursing staff in theEDhad attended safeguardingtraining. We were told that there were plans to implement safeguarding level one and two for all ED staff but we saw no evidence of this.
- Not all the nursing and medical staff we spoke with had knowledge of what constituted a safeguarding concern. Clinical staff did not always followed up safeguarding referrals. The ED had no support network in place to manage or support people who attended ED on regular basis and most did not have safeguarding proformas completed.
- Nursing staff at the children's ED were clear about child safeguarding and could describe the procedure to be followed if there was a concern about a child. If there were concerns regarding child welfare, the senior nurse in charge would discuss it with the safeguarding lead. Out of a total of 14 nursing staff in children's ED , 12 had attended children's safeguarding level 3 training between April and September 2015.

- We reviewed a sample of patient records and found one record where safeguarding referral had been completed appropriately using the trust safeguarding process.

Mandatory training

- Nursing staff were required to complete mandatory training in areas such as infection prevention and control, moving and handling, safeguarding children and vulnerable adults, and investigating incidents. In addition to that, ED staff also received training in areas applicable to their role such as medicines management, and resuscitation training, including, advanced paediatric life support (APLS), advanced and immediate and paediatric life support (AILS).
- The trust target was to have 95% of staff completed mandatory training. Trust data, as of March 2014 – July 2015, showed compliance with the target was poor in many areas. Only 51% of medical and dental staff had completed basic clinical resuscitation training, whereas around 85% of the nursing staff had completed the same training
- The performance dashboards for ED showed that compliance with achieving the mandatory targets had been poor over the previous 12 months. There was no lead for education within the department and staff were responsible for maintaining their own training, which meant that training could be missed.

Assessing and responding to patient risk

- Some members of staff had reported aggression from the public visiting the department; however, there was no risk assessment about the safety of staff in place and staff were not provided with panic buttons' in the event of being faced with aggression and violent behaviour by the patients or their relatives.
- The clinical director told us staff did not receive specific major incident awareness training. Staff told us they had received conflict resolution training and would call the security or dial 999 for police assistance if required. The trust had not provided the security staff with training on conflict resolution and violence and aggression.
- Patients either presented to the emergency department themselves or brought in by ambulance. The receptionist booked patients into the department and asked routine questions to determine the nature of their ailment. Nursing staff triaged all ED patients according to their medical needs.
- A qualified ED nurse or an experienced band five nurses screened and triaged patients brought in by ambulance depending on the severity of their ailment at the "Pit Stop".The aim was to triage all patients inEDwithin 15 minutes of arrival at the department.The nurses directed patients to the appropriate area of the department to be seen by the qualified clinicians. We did not see data or audit evidence to confirm that allpatients were in fact triaged within 15 minutes.
- All patients admitted to the HDU (majors) were placed on a specific care bundle to ensure they received the right level of care. Staff were aware of the appropriate actions to take if patients deteriorated. We reviewed patient's records and noted that staff had escalated patients' needs correctly.
- Staff knew how to escalate patients' needs in response to key risks that could affect their safety, such as staffing and bed capacity issues. There was an escalation and bed management policy in place with daily involvement of matrons and senior staff to address these risks.

Nursing staffing

- There was no specific nursing staffing tool used to determine the level of nursing staffing needs of the department. The matron assigned nurses of differing grades to each of the patient areas in the department. Nursing staff in the majors area were working to a ratio of one nurse to four patients.
- During our inspection, we found the ED was very busy and staff were deployed flexibly in relation to their skills and experience to ensure the different areas of the ED were staffed safely. The overall nursing skill mix was appropriate and included matrons, senior sisters/charge nurses, band five nurses and healthcare assistants all working together in the department.
- The ED held patients handovers two times a day during shift change. Nurses discussed patient's condition, complaints, concerns or incidents at the handover meeting.
- Nursing rotas we examined for the period of four weeks prior to the inspection showed the department to be fully staffed during that four week period. Senior managers informed us that they used agency nurses from two agencies. We spoke with agency nurses who told us they had worked in the department before and knew how to use the electronic patient records system. We also observed them being inducted by a senior nurse before the start of the shift.

- However, in the children's ED, not all staff were paediatric trained, and there was evidence of competency training for adult trained nurses working in that area. Paediatric nurse staffing levels were challenging and not all shifts had a paediatric-trained nurse on duty.

Medical staffing

- Consultant cover was from 8am until 10pm seven days a week. There was an on-call rota for consultants out of hours. Consultant handovers took place twice a day and this was in line with nursing handovers, which also took place twice a day.
- The College of Emergency Medicine (CEM) recommended a minimum of ten consultants in each emergency department. The department employed 50 WTE medical staff, 19% of this were consultants, 12% middle grade doctors, 39% registrar group doctors and 30% junior doctors. The consultant level was therefore just below the recommended minimumCEM level. Lack of medical coverwas listed on the trust risk register as insufficient to provide 24 hour cover resulting in a reduced consultant led service. The mitigation action plan was to continue a consultant recruitment campaign.
- Recruitment of medical staff had been very challenging for the department; locum, bank or agency staff covered existing vacancies. Locum and permanent staff covered a variety of shifts throughout the day. Medical doctors told us there were generally sufficient numbers of medical staff with an appropriate skill mix to ensure patients were safe and received the right level of care. However, when the department was busy, the staffexperienced the impact of shortage of staff and the extensive use of agency and locum staff, because they had to work with staff shortages and at the same time supervising the agency nurses they were working with.

Major incident awareness and training

- The trust had major incident plan, which were accessible to staff on the intranet. The ED senior staff completed periodic reviews of the major incident plan to ensure they meet the changing circumstances and needs of the service.
- Nursing and clinical staff were aware of emergency planning procedures, including the trust business continuity plans. They understood and were able to describe their role and the command structures, which were in place. Action cards were held in all areas with specific guidance to staff. The major incident plans, business continuity plans, and action cards were all available on the trust intranet.
- We saw major incident equipment stored securely, labelled and ready to be taken into use. This included equipment's for specific staff corresponding to action card roles, making identification of roles easier for other staff and other agencies who may be involved.
- The ED had decontamination facilities and equipment to deal with patients who may be contaminated. The management kept equipment to deal with decontamination in a designated decontamination room in the department.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The emergency department used evidence-based guidelines by the National Institute of Clinical Excellence (NICE) and College of Emergency Medicine (CEM) to inform their practice, for example, there were a number of care bundles in the department for patients with specific conditions to follow, such as stroke, diabetes, catheter and sepsis care bundles. The ED care bundles, policies and procedures were written with references from NICE guidelines and these were updated as national guidance changed.

The department participated and performed poorly in the College of Emergency Medicine audits on renal colic, fractured neck of femur and consultant sign-off; and there were no clear action plans drawn up by the department indicating what actions were taken as a result of the audits.

There was a multidisciplinary approach to care and treatment and staff worked with other health and social care providers to assess, coordinate and plan individual patient care and treatment.

Evidence-based care and treatment

- Medical and nursing care followed recognised care bundles as appropriate and clinicians refereed patients on to specialist consultants or departments.
- Care bundles were available at the department, and they were put into action as soon the patient entered the department, this demonstrated that patients were seen and treated effectively by the appropriate staff and that diagnostic tests were carried out and results reviewed promptly.
- The ED completed a number of local audits such as pain control, infection prevention to assess compliance with local and national guidance. Junior doctors completed other audits as part of their training and shared their learning with the department. The ED consultant led the audit team. Some of the audits undertaken were on delayed discharges and pain management. The ED consultant shared audit results with staff at team meetings and team days.
- Clinical guidelines were accessible on the hospital's intranet by staff. However, some of the guidelines in use by the department including bronchitis guidelines have passed their 2014 review date.
- The patient assessment record reflected evidence-based guidance for effective risk assessment and included tools for assessing patient risks such as sepsis so that if the patient's condition deteriorated, medical staff could be alerted quickly. However, we did not see evidence of consistent use of Venous Thromboembolism (VTE) risk assessment in use within the department and this was reflected when patients were admitted onto inpatient medical wards.

Pain relief

- The department had participated and performed poorly in the national College of Emergency Medicine (CEM) audit (2013/14) in providing pain relief for patients with renal colic and fractured neck of femur. The audit assessed the experience of patients in the department in relation the pain control. There was also no evidence of evaluation and re-assessment of pain for patients with the above-mentioned conditions. The result of the audits showed room for improvement such as timely assessment of pain. However, the ED had not taken in response to the audit. We asked for the action plan as result of the audit and none was available.
- Patient records indicated that staff had documented a pain score for each person and this had been followed up appropriately. We saw staff noted when pain medication had been offered to patients in pain. However, we asked three patients waiting in the initial assessment area if they had been asked about pain or offered pain relief when they had first spoken to a nurse. They all told us that staff had not asked about this.
- We observed many examples of staff asking patients if they were comfortable, checking pain levels and providing them with analgesia (pain medicine).

Nutrition and hydration

- We spoke with15 patients in the assessment unit of the ED who told us they were offered drinks at regular times and water was always available. Kitchen staff offered patients the choice of sandwich and hot drinks at lunch and during regular intervals, however, there was no provision of hot meals in the department.
- Patients in HDU and Assessment Units were offered sandwiches, snacks and drinks if their condition allowed and those whose condition did not allow the intake of food and drink were risk- assessed using recognised nutritional assessment tools.

Patient outcomes

- The trust told us the ED had a dedicated clinical audit lead who worked with the clinical audit facilitator to develop and approve the audit program of the department and monitor clinical audit performance. This person acted as a champion for clinical audit within the department, encouraged a culture for clinical improvement and involvement in clinical audits by staff of all levels working within the department.
- The ED had participated in various College of Emergency Medicine audits in 2014 - 2015, which included standards relating to renal colic, fractured neck of femur, sepsis and septic shock and consultant sign-off, so that it could benchmark its practice and performance against best practice and other emergency departments.
- The department performed poorly in the College of Emergency Medicine's (CEM's) renal colic audit 2013/14 and did not meet the required standard in respect of the provision of prompt pain relief in renal colic as follows:
- Only 15% of patients in severe pain in renal colic(against a CEMtarget of 90%) had their pain assessedevaluated within 60 minutes.

- Only 25% of patients in severe pain received analgesia within 30 minutes (against a CEM target of75%), and only 63% of patients received pain relief within an hour (against a CEM target of98%).
- For severe sepsis and septic shock, only 68% of patients had intravenous crystalloid fluid bolus given (against a CEM target of100%).
- Only 24% of patients had their first intravenous crystalloid fluid bolus given within one hour (against a CEM target of 75%).
- The consultant sign-off was 13% against the UK average of 14% for patients seen by the consultant before been discharged.
- The department performed poorly in relation to pain relief for those patients in moderate pain. None of the patients received pain relief within twenty minutes and thirty minutes of arrival at the department, and only 40% of patients received pain relief withinan hourof their arrival at the department.60% of patients did not receive pain relief withinan hourof their arrival at the department.
- There were no action plans in relation to these audits and raising awareness about the importance of re-evaluation of pain in patients with renal colic and fractured neck of femur and the provision of information about management of and re-evaluation of pain in patients with renal colic. The trust was not able to provide assurance of action plans in place to improve its performance in future CEM audits.
- Unplanned re-attendance rates within 7 days of discharge from January 2013 – March 2015 was 11% on average, which was worse than the England average of 7%.
- Staff professional registrations were kept up to date by the department, and wewere shown evidence of this by the matron.
- Documents submitted showed that 80% of ED clinical staff had received appraisals for the year 2014/15. The staff we spoke with told us they had received an appraisal within the last year and had found this process helpful.
- The junior and middle grade medical staff we spoke with during our focus group sessions told us that theywere supported by the consultants,whohad an open door policy for any doctor to see them to discuss any issues/concerns if they so wish.
- We spoke with agroup ofagency nurses working in the department and some of them confirmed the ED had not provided them with orientation to the department and were working on their own. One staff nurse confirmed some agency staff did not have the required skills such as phlebotomy and cannulation needed to workin the ED.
- The nursing and medical staff we spoke with were positive about on the job learning and development opportunities provided by the department. Medical staff told us clinical supervision was in place and adequate support was available for revalidation.

Multidisciplinary working

- The ED held daily multidisciplinary team meetings involving doctors, nurses, physiotherapist and occupational therapist to discuss patients in the department to ensured clinical staff assessed patients and provided them appropriate care and treatment.
- The clinical lead for the ED described how treatment of patients was dictated by the patient's individual needs; with different specialities, working together to ensure that clinically appropriate care was provided for the patient. They gave examples of how patients were assessed against recognised care pathways and national guidelines, which dictated patient's progress from admission to discharge. During our inspection, we observed how doctors with different specialist skills assisted with initial examination and treatment of the more serious patients, providing more holistic care and treatment.
- The mental health liaison team provided support to patients with psychiatric problems and worked with staff in the emergency department 24 hours a day, seven days a week. The team worked within the department to assess and treat patients with acute mental health conditions. However, there was always a delay in seeing children with mental health condition by the Child and Adolescent Mental Health Services (CAHMS) team, as the team could only see children on the ward rather than the ED, and this caused delays in children being seen by the team in a timely manner.
- A consultant liaison psychiatrist could be called to see patients who needed psychiatric assessment. The ED team had their own pathways, management plans and confidential systems in place for treating mental health patients.

- There was evidence of good partnership working with the local ambulance service, with regular meetings between the matron and the liaison staff from the ambulance service to ensure they worked cooperatively and kept delays to a minimum.

Seven-day services

- The emergency department offered all services where required seven days a week with full access to imaging and pathology services 24 hours a day. There was a consultant out-of-hour's service provided via an on-call system. The pharmacy services opened Monday to Friday from 8am to 5pm and from 9am am to 1pm on weekends and bank holidays. The department keeps a stock of common drugs to help with discharge outside of these hours.

Access to information

- The department had a computer system that showed how long patients had been waiting and what treatment they had received. Senior nursing staff could access records including test results on the trust's computerised system using their allocated individual password.
- Clinical staff stated the computer system allowed them to check records from any available terminal connected to the trust network. This meant, during discussions over the telephone with GP's and specialist doctors, the clinicians could view the latest test results, past medical history and current observations. The system also made it easier for senior staff to check results, scan reports, identify and call back patients who had been discharged with a clinical problem unresolved.
- Information and guidance for staff was available through the trust intranet site. Information available included policies and procedures related to the department. The ED notice board had information displayed for staff

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Clinicians obtained written consent from patients or their relatives before providing care or treatment such as anaesthetics. Staff who had the appropriate skills and knowledge recorded consent from patients.
- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained to them in a way that they could understand before the intervention was carried out. Parents and carers of children were asked for verbal consent to care and treatment of their children. All the staff we spoke with in children's EDwere aware of Gillick competence. This is a decision whether a child of 16 years or younger is able to consent to his/her own medical treatment without the need for parental permission or knowledge.
- Records provided by the trust showed that 77% of nursing staff and 62.2% of medical staff had completed training in the Mental Capacity Act (MCA) 2005. We noted that most of the staff we spoke with could articulate an understanding of the Mental Capacity Act requirements and the meaning of deprivation of liberties safeguards (DoLS). None of the patient's record reviewed required MCA or DoLS assessment.

Are urgent and emergency services caring?

Good

We observed staff treating patients with dignity and respect. Patients, relatives and carers told us that they were well informed and involved in decisions about their care and treatment. They spoke positively about the care and treatment they had received. We observed and saw many positive and caring interactions between staff and patients. This included not only nursing and clinical staff, but also porters, housekeeping staff and receptionists. We saw that staff were friendly and courteous with a quiet, calm and relaxed manner.

The department had worked hard to increase the friend and family test response rate and the resultant scores were positive. However, the relatives' room in the departmentwas an unsuitable environment for distressed family members because it was a glass room, which offered no privacy to the bereaved or distressed family members.

Compassionate care

- Throughout our inspection of the ED, we saw staff treated patients with compassion, dignity and respect, for example we saw patients been assisted to eat and drink.

Urgent and emergency services

- We spoke with 12 clinical and non-clinical staff of all grades, and they all displayed passion for delivering quality care and gave us an overall sense of provision of good care for patients. We saw nurses talking to the patients and providing re-assurance, and in one instance, a staff called patients son to inform him of his mother's admission to the department. This was also evident during our observations of interactions between patients and staff in the department.
- The majority of patients and relatives we spoke with during the inspection were positive about the care and treatment provided. We spoke with 15 patients and most of them told us that they were happy with their care. They told us, "The care is much better here, and the staff were very good". Another patient said, "I have received good care".

Understanding and involvement of patients and those close to them

- Patients told us staff took time to explain test results, their implications and side effects of medication in a way they could understood. Patients and their relatives could speak with staff in private if necessary. Patients said nurses and doctors were understanding and supportive. A relative said, "I have been treated well and have no complaints, all the staff were very kind and respectful".
- Nurses explained care and treatment to patients in a way they could understand. However, some patients also told us clinical staff did not always communicate with them as they would wish, and they were sometimes kept waiting without been told about what they were waiting for.
- Nurses gave patients a "patient passport" which provided them with progress information about their stay at the department, information such as waiting time, availability of transport or specialist input was documented in the patient passport.
- Doctors and nurses consulted patients and relatives about the patient's treatmentinvolving thin their care. We observed positive interactions between staff, patients and their relatives when seeking verbal consent. Nurses sought consent from patients before providing care and treatment.

Emotional support

- Nurses supported patients by providing them extra pillow, hot drinks and cold snacks. We saw nurses providing re-assurance to patients and offered emotional support. Relatives were able to remain with patients throughout their time in the ED.
- Nursing staff supported patients and their relatives as much as they could. Patients and relatives thought the staff were helpful when approached.

Are urgent and emergency services responsive to people's needs?

(for example, to feedback?)

Requires improvement

There had been a continuous and persistent deterioration of the department's performance against the four hour target to see and treat people. We saw five patients waiting in excess of 14 hours waiting to be admitted. Patients did not always receive care and treatment in a timely way. The department had consistently failed to meet key national performance standards for emergency departments.

Black breaches increased from September 2014 to December 2014 and reduced from April 2015 to June 2015 but were on the rise again. Black breaches had occurred in significant numbers over the previous 18 months. Between September 2014 and August 2015, there were 1,389 black breaches at the hospital. A black breach means a patients waiting more than an hour in an ambulance because they could not be admitted to an Emergency department due to lack of beds.

The hospital identified themes and trends from the investigation of complaints. Action plans were prepared following complaint investigations and there were several examples of actions the department had taken in response to complaints, including changing practice and guidelines.

We observed many instances when it was very difficult and challenging for staff to provide privacy and protect patients' dignity because of the nature of the "Pit Stop" where ambulance crew handover patients to the nursing team in an open corridor by the entrance to the department.

Urgent and emergency services

Service planning and delivery to meet the needs of local people

- The ED management monitored bed capacity daily in a bed management and safe staffing meetings. The trust had identified that reconfiguration, particularly of the acute medical beds, was required to meet patient needs and was building an additional 64 beds to meet the increasing demand of the service.
- The ED senior management informed us they were aware that the emergency department and acute medical service pathways did not fully meet the needs of patients in the trust's catchment area for urgent and emergency care in their present form.
- Ambulatory care services were available to alleviate patient flow pressures by working closely with GP's to initiate admission of appropriate patients into their area for rapid treatment, diagnostic testing and discharge.
- Upon admission, patients were allocated a named nurse to ensure continuity of care. We observed ambulance crews worked with the hospital staff to ensure continuity of care by making sure all information about patients was handed over to the staff at the "Pit Stop" handover.
  - However, at the ambulance receiving area ("Pit Stop"), we noted that patients were handed over to the nursing or medical staff at the corridor near the door. People walking by could hear the conversation between the ambulance crew and the staff. There was no privacy and or dignity been accorded to patients during the handover. Nurses took patient's initial observations in the corridor. Patient's confidential information and conversations could be overheard by other staff, patients or relatives passing by.
  - Patients, relatives and staff were consulted in the design and building of the department. The trust built a separate children's emergency department to cater for the needs of sick and vulnerable children.

Meeting people's individual needs

- Care bundles were in place for the care and treatment of patients with complex needs, including those in paediatrics. End of life care plans were readily available in the department for patients who needed end of life care.
- The department was accessible for people with limited mobility and people who used a wheelchair. There were no wheelchair available outside the walk-in entrance for people who drove directly to the department, and the department had only one wheelchair and trolley, which could accommodate bariatric patients.
- The service took account of the individual needs of different patient groups. Staff had access to information about different cultural, religious and spiritual needs and beliefs. Translation and interpreting services were available for patients who did not speak English, or who had other communication difficulties and staff were aware of how to arrange these services.
- Care bundles were in place for adults with learning disabilities who regularly accessed the emergency department for reoccurring and on-going conditions. If a patient was identified as living with dementia or had learning disabilities, staff could contact specific link nurses for advice and support. We saw information and contact details of the link nurses at the nurse's station.
- There was a dedicated room with minimal furniture where mental health patients could be accommodated. During the onsite visit, we noted patients with mental health conditions and patients with learning disabilities being cared for in a dedicated room with a security guard station outside to supervise the patients. Nursing staff cared for "at risk patients" in a dedicated room that allowed them to be closely supervised and monitored.

Access and flow

- Access to beds in the hospital did not follow an agreed pathway; identifying accessible beds presented a significant and constant challenge for the hospital, and staff told us it was a usual for beds to be suddenly become available at 11pm. This contributed to significant breaches in the ED's decision to admit (DTA). In December 2014, there were 225 breaches on waiting for beds at the hospital.
- Patients did not always receive care and treatment in a timely way. The hospital was consistently failing to meet key national performance standards for emergency departments. There had been a continuous and persistent deterioration of the department's performance against the four-hour target to see and treat people within. We saw five patients waiting in excess of 14 hours waiting to be admitted.
- Three patients provided negative feedback about the long waiting times, particularly during busy hours. Patients told us nurses do not always kept informed

about the waiting times and when a doctor would see them. Most patients we spoke with told us they have been waiting in excess of four hours to be seen by a doctor.

- The ED consistently failed to meet the national four hour wait target, which requires that 95% of patients were discharged, admitted or transferred within four hours of arrival at ED. The ED had not met the standard from October 2014 – June 2015. Sample data from 15 June 2015 to 16 August 2015 showed a declining trend from a maximum of 83% down to 67% performance.
- An indicator of how long patients waited for their treatment to begin was also measured. The national target was a median wait of below 60 minutes. From January 2013 to July 2015, the average wait was 55 minutes.
- Percentage of emergency admissions via ED waiting between four and 12 hours from the decision to admit until being admitted was consistently higher than the national average. From July 2014 – July 2015, the hospital average was 25% as compared to the national average of 5%.
- The percentage of patients leaving before being seen was around 3%, which was above the national average of 2%. This is an indicator which determines the level of dissatisfaction by patients waiting to be seen (the length of time patients had to wait to be seen).
- Managers told us the main issue with maintaining compliance with the four-hour target was patient flow, particularly for patients who were waiting for medical beds. We noted that there was a coordinated effort by the trust to address this issue at the trust level. Local managers told us they were meant to address the issues in isolation, even though there was an escalation and surge policy but this had not been embedded within the trust. There was no evidence of staff working well together to monitor patient flow or evidence of the escalation plan being implemented when necessary.
- Black breaches increased from September 2014 to December 2014 and reduced from April 2015 to June 2015. Black breaches had occurred in significant numbers over the previous 18 months. Between September 2014 and August 2015, there were 1,389 black breaches at the trust, which was higher than the England average. The weekly numbers of breaches varied fromthree inone week of less pressureto 79 in one week during winterpressure.On a monthly basis the lowest figure was in September 2014 with 30 black breaches and the highest in December 2014 at 225.Performance information since the opening of the new department indicated a marginal improvement was achieved in most performance data.
- Patients who arrived by ambulance, other than those who needed to go immediately to resuscitation, were seen by a Rapid Assessment and Treatment (RAT) clinician. RAT typically involves the early assessment of 'majors' patients in ED, by a team led by a senior doctor, with the initiation of investigations and/or treatment. This process ensured that patients received an early diagnosis by a clinician and increased the probability of a positive outcome. However, patients who walked into the department through the UCC were seen by a receptionist and then streamed to the ED to be seen by a doctor and a nurse or, if less serious, the patient would be seen by the UCC, which opens 24 hours a day, seven days a week managed by a separate provider

Learning from complaints and concerns

- We saw information displayed around the department that explained to patients how they could make complaints and give feedback and this information is in English, and none in other languages or format.
- Nursing staff were aware of how to manage complaints and how to support patients who wished to complain. We spoke with both clinical and non-clinical staff who told us they knew how to put patients in touch with the Patient Advice and Liaison Service (PALS). Information about PALS was displayed in patient areas at the department.
- Staff told us that they tried to address patients' concerns before they made a complaint.They said a regular source of concern for people was the long waits before been seen by a doctor after booking into the department.
- The ED held quarterly team days where learning from complaints were shared with staff. Team days are a form of team meetings with developments and learning theme.
- The Patient Advice and Liaison Service (PALS) directed patients who want to make complainants and assisted in the investigation of complaints. Managers shared actions from complaints investigations by emails and during team meetings. Managers told us there was a

system in place to follow up actions from complaints and to ensure those actions were completed and lessons shared in team days. We saw the minute's book of team days, which confirmed this.

Are urgent and emergency services well-led?

Requires improvement

We found the well-led domain of ED services required improvement because the trust's vision and strategy for the department did not enable it to cope with the demands placed on services on a daily basis. ED staff had given up looking for trust-wide solutions because theyreported they got little strategic direction and support from the corporate leadership to address the issue of capacity and perceived that they were left on their own.

The management had persistently been unable to deliver the national four hour target for patients to be seen, treated, admitted or discharged. The four hour target performance had deteriorated considerably. Governance arrangements were not fully embedded within the department to allow monitoring the performance. Governance arrangements were at the trust wide level and not departmental focussed.

The trust had an open culture and staff and local managersreported beingconfident about reporting anything they had concerns about, including when something had gone wrong. Staff were made aware of the trusts strategic objectives, the department was well led locally and senior managers were visible.

Vision and strategy for this service

- The future vision of the ED was not fully embedded within the ED team and was not well described by all members of staff. Staff told us they had a corporate induction that included the trust's core values and objectives; however, some of the staff did not have a clear understanding of what those values and objectives were.
- Staff were aware of the challenges they faced in their own service such as high level of ambulance attendances and patients waiting for over four hours to be seen, treated, admitted or discharged, and their inability in achieving the four hour target.
- Some of the ED staff we spoke withsaid they could participate in improving the department's performance and patient's experience if they were actively involved. Staff were aware of the key performance indicators set for their department and how they performed in relation to them.
- The trust had a strategic vision in the provision of ambulatory care service, and the service was driven from within the ED.
- Nursing staff and doctors we spoke with were proud of the hospital; they were enthusiastic about their role and believed they contributed to the vision and values of the hospital, however we were told that senior management were not visible within the department and had left the department to deal with the issues they were facing.

Governance, risk management and quality measurement

- We spoke with the lead consultant for the department and other consultant medical staff as to the functioning of the governance arrangements. Senior staff told us the governance structures were recently changed and the revised structures were yet to be embedded into the functions of the department.
- Members of the nursing staff were aware of their specific risks, but could not demonstrate to us what was contained in their department's risk register; there were no formal discussions of the items on the risk register.
- The risk register highlighted risks across the ED and actions plan to address concerns, for example in relation to concerns regarding long waits and flow within the department.
- Senior managers were able to identify the top risks within the department including overcrowding in the assessment waiting area, meeting the four hour target and caring for patients at risk of self-harm. There were plans in place to monitor and address these risks.

Leadership and culture within the service

- Nursing staff in the department expressed concern about a lack of visibility of trust's leadership. There were two matrons in the department, and between them

covered the department seven days a week on site who were supported by band seven senior staff nurses. There were also senior nurses present for most of the time coordinating the activities of the department.
- We saw good team working in the department between staff of different disciplines and grades. Staff worked well together and there was respect between specialties and across disciplines.
- The department was medically led by a senior consultant who offered overall clinical leadership to the medical team. TheED nursing leadership was led by the two matrons and they were supported by band seven's senior staff nurses. All the teams had defined areas of responsibility and clinical leadership
- During the onsite inspection, we observed staff were willing to go beyond the call of duty and were a dedicated, passionate and caring towards their patients. However, theyreported they were not supported by the trust's leadership.In some instances they perceived that they were blamed for not meeting the target and performance indicators, which affected their morale.
- We spoke with nursing staff of various grades within the departments in clinical and non-clinical roles and they told us that the culture within the trust did not encourage openness and honesty and there was a occasional blame culture within the hospital.
- Most staff told us that within the department, there was a sense of team working. They thought that the team pulled together in difficult times and supported each other. Some staff told us that theywere under pressure to meet targets and were made to feel as though they had failed to do their job correctly by the corporate leadership if targets were not met.

Staff and public engagement

- Clinical and administrative staff in the ED did not feel engaged outside of the department and demonstrated little awareness of the various initiatives taking place across the trust. One member of staff told us that they just did not have time to get involved in things when they were working.
- There was no information prominently displayed anywhere in the department on how the public could provide feedback to the leadership of the department. There were no mechanisms for public to engage with the department. The clinical staff we spoke with told us they do not routinely asked patients and relatives for their feedback.
- Most of the nursing staff told us they were occasionally engaged with service changes andreported that their views had been heard or acted upon. For example, their input and concerns were taken on board during the design of the new ED.
- The ED held nursing team days every four months for nursing staff. Minutes of these team days were kept in the communication book. Nursing staff also told us that they received numerous email communications. However, because of the busy nature of the department, they did not have time to look at them, let alone read them.

Innovation, improvement and sustainability

- The opening of the new emergency department represented a substantial improvement in the provision of urgent and emergency services at the hospital, so that emergency care and treatment was provided in a suitable environment. The newly built 64 medical bed unit due to open shortly is due to ease the pressure of the emergency department.

Medical care (including older people's care)

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

Information about the service

Inpatient medical services at Northwick Park Hospital (NPH) comprised of wards called Kingsley (Clinical Haematology), Sainsbury (private patients), Dickens and Dryden (Acute admissions and medical units – AAU/ AMUs), Jenner and the Coronary Care Unit (Cardiology), Clarke and Defoe (Infectious Diseases), Hardy and Fielding (Care of the Elderly), Haldane and Herrick (Stroke including hyper acute), Gaskell (Respiratory), James (diabetes, endocrinology and rheumatology) Regional Rehabilitation Unit (neurological rehabilitation), and Byrd (Gastroenterology).

They had 26,500 admissions in 2014/15, 66% emergency, 2% elective, 32% day case. 63% general medicine, 12% medical oncology, 10% clinical haematology, 10% others.

We visited all but Sainsbury ward and the discharge lounge. We spoke with 51 patients, checked 31 pieces of equipment, reviewed 28 patient records. We spoke with over 60 members of staff including nurses, doctors, allied health professionals such as physiotherapists and occupation therapists, administrative and ancillary staff. We also spoke with management at various levels from ward to division level.

Summary of findings

Medical services at NPH required improvement across all key questions other than caring which we rated as good. The biggest concerns were the flow of patients through the medical wards, staffing levels, nutrition and the environment's safety and responsiveness to patient needs.

Governance and leadership also required improvement. Although there was some risk awareness and a strategy going forward, cross site working was in its infancy and performance was not fully monitored.

Other areas of concern including patient record completion, mandatory and competency based training. A number of areas of where understanding and performance was limited or variable included adherence to the Mental Capacity Act or engagement with staff and the public.

However, most of the patient feedback we received was positive including involvement in care and privacy and dignity. Patients who deteriorated or were in pain were well managed and patient harm was being actively reduced. Complaints were responded to and acted upon. There was good local leadership at ward and department level.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Medical services safetyrequired improvement. Nurse staffing levels did not always meet the acuity and dependency of patients, with a high use of agency staff and a variable amount of vacancies. Medical staffing was mostly appropriate although there was some high use of junior doctors and a lack of senior staff overnight on site presence.

Although most equipment checks were in date, the environment on a number of wards was not fit for purpose, particularly in regard to Kingsley ward. Wards were mostly clean and infection control prevention guidance was mostly kept to although we saw a number of examples of poor practice.

Patient records were not always complete or legible. Training rates were below the trust target. Staff were aware of how to report incidents and learnt from them but they were not always shared fully and not always properly investigated.

Patients were appropriately escalated and treated if they deteriorated. Patients came to harm around the same amount as other trusts and actions were being taken to reduce harm. Medicines were mostly well managed. Staff were aware of their safeguarding adults responsibilities.

Incidents

- Medical services at NPH reported 22 serious incidents in 2014/15. Of these, ten were grade three pressure ulcers, three were grade fours and five were other reported pressure ulcers. Another two were reports of sub-optimal care. There were no serious incidents declared on Hardy, Fielding, Dickens, Gaskell, Jenner and one each on James, CCU and Kingsley although doctors told us they had no recent incidents on Kingsley. One ward had brought in a new skin chart after an acquired pressure ulcer.
- A total of 9402 incidents had been reported within medicine across the trust in last 12 months. These were mostly pressure ulcers, admission delays, falls, administration of medicines, and 'other'. Other incident categories had less than 100 incidents each.
- There had been two never events at NPH, an incorrect blood type and a misplaced nasogastric (NG) tube. Since these incidents, staff have had training and an improved labelling system for blood bags and nasogastric tubes practice was taught specifically to junior doctors. However, the Nutrition Policy covering nasogastric tube insertion technique and confirming tube position was out of date and due for review in 2011. Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.
- Staff were aware of how to report an incident or near miss and they received learning from incidents they reported via email, from the wider trust and high profile cases at other trusts. Doctors described doing teaching on prescribing errors after a recent incident. However some staff told us they had never reported an incident despite being at the trust many years.
- Minutes of meetings we reviewed were variable with some discussing incidents in their own area or the wider division, whereas others had no clear discussion. Medicine error incidents were reviewed by the medicines safety committee and learning was shared across staff via medicines safety bulletins.
- We reviewed four serious incident investigations. They did not follow appropriate root cause analysis process as although a chronology of the incident, immediate actions and recommendations were stated, there was no contributing factors, or root cause analysis process shown such as fish bone analysis or five whys.
- There were 468 incidents overdue at NPH out of 5656. These were mostly respiratory, ward managers or matrons, of which 19 investigations were for serious incidents.
- There were triggers on the electronic incident reporting system for duty of candour when an incident was graded as moderate harm or above incident and this was trained as part of risk management.
- There was awareness and training on Duty of Candour including the need to investigate and apologise for near misses at a moderate harm level at ward manager level. However this was not the case for staff below, including allied health professionals.Duty of Candour is a regulation under the Health and Social Care Act which aims to ensure that providers are open and transparent with people who use services and their carers. It sets out

some specific requirements that providers must follow when things go wrong with care and treatment including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- There was a lack of evidence of mortality and morbidity meetings although some staff told us they did take place on at least a monthly basis.
- There were staff representatives for medical devices to deal with an incident or alert regarding a device.

Safety thermometer

- Safety thermometer results were displayed on the wards but results varied. Some wards had high amounts of falls including the stroke, gastroenterology and care of the elderly wards with over 20 each in 2015/16 whereas others had less than ten. Some wards also had high amounts of pressure ulcers such as the AAU/AMU had over ten each. Overall, NPH was around the national average for pressure ulcers, urinary tract infections (UTIs), and falls (three a month).
- Audits for assessments and care bundles varied. Cannula compliance was mostly above 95% but a couple of wards had been below 90%. Venous thromboembolism (VTE) assessment compliance was mostly over 95%. Pressure ulcer care compliance was at or nearly 100%. Those that had poor performance had brought in additional checklists which had started making improvements.
- VTE assessments we reviewed were not always completed but care bundles for skin, falls and catheter care were mostly in place. However the care bundles were not individualised to the patient.
- Senior staff acknowledged there were a high number of falls in some care of the elderly wards and they felt this was due to a reduced nurse to patient ratio. However a falls committee was in place and some wards had taken other actions such as nurses dedicated to one bay or bed alarms.
- We saw evidence that patients that had either acquired or had pressure ulcers on admission were referred to the tissue viability nurses who gave appropriate advice and interventions.

Cleanliness, infection control and hygiene

- There had been 13 clostridium difficile (C Diff) in a mix of wards and two cases of Methicillin Resistant Staphylococcus Aureus (MRSA) but both the trust and ourselves could not identify a trend. Audits for assessment of MRSA were 97% or higher.
- Cleanliness audits showed all wards at 93% or above in recent weeks, with those deemed high risk for infection areas targeted to achieve a higher cleanliness score. However, audits were not recorded for all wards every week, with some only submitting one audit over a two month period.
- Most of the equipment and environment we checked was visibly clean. Most equipment had stickers to show they had been cleaned in the last 24 hours although there were a few examples of cleaning last done a few days prior. However, although the sluices on the AAU/AMUs were supposed to be checked twice a day, we saw some gaps in these checks.
- Cleaning equipment was appropriately colour coded and a key was provided to show what area was cleaned by which colour.
- There were positive ventilation rooms at NPH and side rooms were available for infectious patients in most wards.
- Isolation signs were in place and appropriate infection control equipment was available and used.
- There had been pseudomonas bacteria in the water on Kingsley but we saw filters had been put in place on the sinks.
- We saw some isolated examples of poor infection control practice such as linen left on a bin when a nurse was putting gloves on, staff wearing nose rings and hooped earrings that were not covered and name badges that were made of paper.
- Hand hygiene audits were mostly above 95% on inpatient wards although Dickens and Jenner were much lower than this. Some areas were not submitting audits. Hand sanitisers were in each bay. Patients told us the wards were kept clean and staff washed their hands although one patient said they observed two cleaners who were not as thorough as others.
- Staff observed bare below the elbow practice in all clinical areas that we inspected.

Environment and equipment

- The equipment audits we reviewed showed most wards were at 100% compliance or just below with very few resuscitation trolley checks missed.

- Equipment checks we reviewed were up to date including resuscitation trolleys. Maintenance records for requests for repairs were also up to date. However, some old servicing dates were left on equipment which were at risk of causing confusion.
- Staff told us there was not normally an issue with lack of equipment and they could borrow from neighbouring wards if necessary. However some staff told us equipment had been broken for more than a year and only recently had been repaired. We also noticed the blood pressure machine was broken on Dryden and the bed pan washer had been out of service for a few weeks on Byrd.
- There was a poor environment on the stroke wards, Clarke, Byrd, Kingsley and RRU. Kingsley had no negative or positive pressure rooms. Therefore portable air condition units were used to filter the air. However staff were unaware how often the air filters were changed and this was not made clear when we requested this information from senior staff.
- The store room on Kingsley was previously a shower room and still had running water from the taps plus multiple pieces of equipment stored were out of date. There was no order to how items were stored and it was very cramped. Clocks were stored with dressings. Senior department staff told us they had arranged shelving, and monitoring of the storage area plus had removed the items that were surplus. In addition, they had made the decision not to remove or close the taps as the room was likely to be reused as a shower room once the wards were reconfigured.
- The bedrooms on Kingsley had no ante-rooms to put on PPE or wash hands which meant staff would have to put on PPE in an unsterilized corridor or whilst in the room.
- There was a long distance between the two infectious diseases wards and a doctor was not always stationed on Defoe. Therefore, if a patient deteriorated, there could be a few minutes delay in a doctor responding.
- Day Case service were due to move from Kingsley ward to a specially created day case area in the old A&E which was under construction during the visit.Kingsley was noted as being an inappropriate ward for the patient group in the divisional plan.
- There were concerns with the dirty utility door in Byrd ward as there was a button to enter but none to exit which meant staff could be trapped if they did not prop the door open. There was a similar door on Clarke ward but instead of a hydraulic lock, it was padlocked so staff could still get in and out.
- Closed sharps bins were unlocked and there were a few examples of sharps bins not temporarily closed when they were not in use. Other waste bins we observed were used appropriately and not over full.
- The discharge lounge had portable oxygen and either call bells or hand bells for patients in the beds. However it had no resuscitation trolley so would have to use one from Dryden or Dickens.
- There were negative pressure rooms available on Clarke ward which was appropriate considering it was an infectious diseases ward. However the rest of the environment was in a state of disrepair.

Medicines

- Medicine management audits were 95% or above and none showed controlled drugs (CDs) had missing checks. Controlled drugs we checked were up to date and recorded correctly.
- The CD policy in use at NPH meant that nursing staff in the haematology unit were routinely placing part used CD vials into yellow sharps bins. Whilst there was no legal reason why this cannot be done, there had not been an additional risk assessment for areas in the trust where that was a regular occurrence.
- Most of the medicine fridges we checked were up to date with minimum and maximum temperatures checked. However one fridge on CCU had a high reading but the internal thermometer was in the correct range. Some documents were not clear on dates of checks.
- The use of cabinets was being rolled out across parts of the trust. These had some patient safety features built in; for example when the pharmacist tried to take a medicine from the penicillin group out of the unit, a warning message regarding penicillin allergy appeared on the screen. Extra security was also built into the cabinets for the storage of CDs. Two fingerprints from relevant staff members were required before the unit would open if a CD were requested.
- They had also implemented fridges which meant that fridge medicines were stored securely and could only be accessed by staff who had been trained.
- The ambient room temperatures were monitored, but were seen to be occasionally above the range allowed (medicines should be stored below 25°c.). The trust

have declared in the risk register that there was a long standing issue regarding difficulty in maintaining appropriate room temperatures. This was because air conditioning units cannot be installed due to asbestos at NPH. However there was a plan in place to address this issue, including an evaluation of the stock held.

- Oxygen was mostly stored appropriately but a few areas were unlocked. Oxygen prescriptions were not always recorded and those prescribed did not always have clear treatment plans. Supplementary oxygen therapy was not always prescribed as it should be according to National Guidelines. Where it was prescribed, the target oxygen saturation was not always specified. We saw two examples of limited oxygen being prescribed but the patient also being prescribed nebulised medications with the driving gas being (unlimited) oxygen which is clearly inappropriate and a risk.
- Staff told us they were giving patient medicines in envelopes due to delays with to take out (TTO) medicines from pharmacy but we found no evidence that this was occurring. Arrangements for dispensing medicines to patients being discharged were appropriate.
- We were concerned about medicine preparation and medicine rounds. Medicine preparation on Clarke ward was at the nurses station which meant there was a risk of being disturbed as it could be loud and busy. However this had been reconfigured on Byrd ward to a cubby area so they were not disturbed, despite the layout of the ward being similar.
- IV fluids and medicines were appropriately stored and locked.
- Medicine management records (MAR charts) were mostly up to date with few very prescription errors or missed doses. Drug histories, allergy status and pharmacy interventions were recorded. Name stamps were used in most instances to show the prescriber.

Records

- There was varied completion of risk assessments with some lacking detail and areas such as waterlow, VTEs were not always assessed or plans were not in place when there was a risk. If a plan was in place, it was not always complete such as dates or reviews. Some staff told us it could take up to seven days for a VTE assessment by a doctor. All the records audits we reviewed were either not applicable to inpatient medical wards or were from 2012.
- We found some records had either illegible or no record of the doctor that reviewed a patient. Some doctors were using stamps whereas others did not. We were told some did not use stamps as the grade or speciality of the doctor quickly became out of date due to their rotations.
- There was no templated seizure chart so staff were writing hand written notes for these which meant there was nothing clear for staff to do to standardise practice or actions in line with national guidance.
- On Clarke ward, fridge checks were in the same place as patient controlled drug information which was not appropriate.
- Nursing and doctors notes were legible and detailed.
- Some staff told us patient records were out of order but clinic letters were available electronically. However agency staff could not access the electronic patient records.

Safeguarding

- Safeguarding training results varied against the 80% trust target. Safeguarding adults level one compliance was as low as 50% in some areas. Safeguarding adults level two was better but many areas were below 70% compliance. Safeguarding children level one was mostly above 80% but level two was mostly below 50%.
- Staff were aware of their safeguarding responsibilities and had specific training regarding awareness and reporting of female genital mutilation. A separate safeguarding referral form was in place but it was not linked to the incident reporting system.
- Staff were able to describe different types of safeguarding concerns and abuse.
- All patients that had a pressure ulcer on admission had a safeguarding referral.

Mandatory training

- Mandatory training rates were mostly improving such as Dickens at around 80% when it had been 64% two months prior against the trust target of 80%. However RRU, the stroke units, Jenner and Kingsley were low at below 70%. Senior nurses on the wards were unable to explain why. The new education and learning management system 'ELMS' system flagged when training was coming out of date.
- Some new mandatory training had been brought in including bloods, nasogastric tubes and pressure ulcer

care. However the take up of this training was still low on some of these wards despite the training being linked to never events and serious incidents. One ward had bloods training compliance at 28.5%.

Assessing and responding to patient risk

- The hospital used national early warning score (NEWS) system to identify when patients deteriorated using different observations such as heart rate, blood pressure and oxygen levels.
- All the NEWS audits we reviewed showed compliance with completing the necessary observations at either 100% or just below. Patient records we reviewed showed patient observations were complete and were appropriately escalated and had medical interventions in a timely way. Observations were also taken in the discharge lounge in case a patient deteriorated. However HCAs were conducting observations and NEWS which there was a risk they were not skilled to do.
- One ward had a previous incident where a patient had not been escalated after a high NEWS score. Therefore staff on the ward were trained and reassessed regarding NEWS.

Nursing staffing

- The service used an approved acuity tool to review its staffing levels and it was due to review all nurse staffing levels in November 2015 and on a six monthly basis.
- There was a trust wide plan to ensure no ward had less than 1:8 registered nurse (RGN) to patient ratio and to move towards at least 1:6. This was being met in most instances both day and night although this was mostly due to high agency and bank staff usage or use of staff that were due to be deployed to the new modular block that was due to open in November 2015. This meant there were a high number of vacancies that had not permanently been filled, particularly on care of the elderly wards, Dickens and Defoe.
- The service used an acuity tool and defined its nursing establishment but this did not take account of environmental issues such as side rooms where patients were out of sight of nurses.
- RRU sometimes cared for patients with tracheostomies although the oxygen flow for these patients were pre-set which meant they did not require as much staff monitoring. They were staffed at five RGNs and seven HCAs during the day, four nurses and three HCAs at night caring for up to 26 patients.
- Patients that had a condition or treatment that required a set RGN to patient ratio had those requirements met, such as those patients on non-invasive ventilation or of high dependency had 1:2 ratios. However, sometimes caring for a high number of these patients impacted on the rest of the acuity and dependency on the ward. Sometimes this ratio was met out of the existing establishment rather than additional RGNs, including on Dryden and Byrd wards.
- Many wards had vacancy rates up to July 2015 of over 20%. Although these had reduced, these were likely to rise again as the new modular block required at least 65 RGNs, and up to 111 depending if the current Clarke and Byrd wards closed. This decision had not been taken at the time of our inspection.
- There were two RGNs and two HCAs allocated to the discharge lounge and they never had to use agency. They felt this was enough to support the acuity of the patients there as well as visit the wards to coordinate the patients to be discharge from the lounge.
- Overseas nurse practitioners were being recruited but senior staff acknowledged these diluted the skill mix at least initially and that there was high turnover to non-medical specialties such as ITU plus acuity was increasing. We were not provided with evidence of induction of agency and overseas staff. To improve retention, some senior staff proposed nurses rotating including with community but we were concerned that if this was between different specialities, this could reduce nurse competency.
- Ward managers were at least partly supernumerary with some doing 40% management, 60% clinical, others had a higher amount of clinical days. However, they were always included in the numbers on shift. Senior managers felt ward managers would eventually be around 50% supernumerary.
- Approval for 1:1 care was quicker than agency with no divisional approval needed. However divisional approval was needed for agency staff although senior nurses told us approvals always came through. Bank staff usage had increased though we understand they received specialist rates.
- A safety huddle was conducted after the bed meeting which should involve the matrons and run by a head of nursing which discussed staffing issues in each area and any staff moves that were required. However, this was not always attended by all those required.

Medical care (including older people's care)

- We saw no evidence of comprehensive recruitment and retention plans beyond the use of bank and agency staff to fill vacancies. We did not see displays on the wards of planned versus actual staffing. We did not see a red flag system when staffing levels fell below a certain level.

Medical staffing

- Medical staffing was mostly appropriate including out of hours despite the trust having a lower amount of consultants than the national average. Separate physician teams undertook patients on take and on the ward out of hours and they both included registrars. At weekends at night medical staffing cover was as follows for the AMU and ED: 1 SpR & 2 SHO's; and for medical ward cover:1 SpR & 2 SHO's. In addition, at night, most specialist wards were covered by the medical registrar rather than specialist doctors although consultants were available in all specialities on-call.
- Junior doctors felt overworked at night and some staff felt this was due to the site team also being overworked. Some junior doctor rotas required a high on site presence at the weekend. Haematology juniors were required on site forone out of threeweekends. However there was a better junior doctor rota on the stroke units.
- The gastrointestinal bleed rota comprised of doctors on-call around once every two weeks although sometimes it was much shorter than that. They were on the weekend rota 1:12.
- There was rarely a need for locums although the new AMU unit had only recruited 1.5 acute physician out of four so the trust and were going to advertise for a geriatrician or other specialist consultant to cover the new AMU. They were also vacant in two middle grade positions although locums would continue to be used to cover this.
- Acute physicians were either on a three or four day rota to ensure continuity of care. Some consultants were on a two to four week rota in other specialities.
- Patients were reviewed at least daily on the AMUs including weekends and were reviewed within the first 12 hours on admission. However some patients told us they didn't see a doctor at weekends.
- Plans were in place to try and recruit medical staff to work cross site but no current plans to recruit physician associates and senior staff acknowledged recruitment was difficult.
- If a patient was an outlier on a ward, the doctors on that ward would treat them rather than the speciality the patient's condition was linked. However, a treatment plan would be arranged by the appropriate speciality on an initial review. The exception was haematology due to the amount of patients that had a haematology condition that was at least secondary to their care. Therefore they had a separate registrar do an outliers round.
- Ward rounds were conducted daily but some speciality wards had consultants review patients twice weekly with a registrar round the other days.
- Staff told us day to night medical handover varied as to whether the consultant attended or not. There was no SHO presence at handover as they were clerking and the site team did not attend until 30 minutes into the handover we attended.
- There was a good medical handover meeting on the AMU/AAU wards. There were poor handovers between A&E and the wards with MRSA screening and medicines management not always clear or complete in the handovers.

Allied Health Professionals

- There were a lack of physiotherapists in endocrinology which meant some patients who required two people to support them during therapy only got one. Physiotherapists were also doing 1:5 weekends.
- Pharmacists were on an out of hours rota once a week but were happy with their workload and how staff managed times of increased activity.

Major incident awareness and training

- There was awareness of what staff needed to do in the event of a major incident including discharging the most fit patients and being deployed wherever staff were needed most.
- Plans were in place for increases in activity including actions for staff if there was a major incident such as bringing in all on-call consultants to work on-site.

Are medical care services effective?

Inadequate

We rated effective as inadequate for medical inpatient services. Nutrition and hydration was poorly managed with poor assessments, choice of food and support for those that needed it.

Medical care (including older people's care)

There was varied adherence to national guidance and we saw policies and procedures out of date, although some were in the process of being updated.

There was varied staff competence, mostly the nursing staff though dependent on their ward.

Multidisciplinary working was variable with a lack of cross site working in particular.

Awareness and application of the Mental Capacity Act and Deprivation of Liberty Safeguards was variable.

There was seven day working but it was limited.

Some patient outcomes werepositive in national audits for which we saw results. However, we did not receive results for many of the auditsreported to.

Pain was well managed and there was appropriate access to information.

Evidence-based care and treatment

- Care of patients on non-invasive ventilation (NIV) followed the National Institute for Health and Care Excellence (NICE) guidance but not all British Thoracic Society Oxygen prescribing guidelines or nebuliser guidelines. NICE guidance was also followed on the stroke, infectious diseases and haematology wards.
- NICE guidance was discussed at clinical governance meetings and updates were fed down from matrons. Some staff had a NICE application on their phone and daily updates came through by email such as medical devices and new guidelines from relevant organisations such as the British Society for Haematology.
- New guidance was displayed in staff rooms and as part of a daily update by email. All current guidance was available on the trust intranet.
- We found some policies out of date and unwieldy or unclear. A risk assessment policy was due for review in 2009. A falls policy was due for review in 2009. Policies and procedures for treatment of patients who had conditions relating to alcohol were in the process of being updated and ratified. The new joint medicines policy is due to be launched across all sites in November 2015.
- Agency staff were able to access the intranet but this was restricted.
- We saw evidence of learning from local audits. The AMU/AAUs had brought in an infection control nurse for each morning due to poor hand hygiene results.
- We requested a sample of local audits but all but one we were sent did not relate to NPH.

Pain relief

- Pain was well managed and staff told us there were no delays in getting the pain team to review a patient.
- Pain scores were recorded and we saw evidence of patients receiving pain relief in a timely manner.

Nutrition and hydration

- Nutrition and hydration was poorly managed.
- We saw some MUSTs (Malnutrition Universal Screening Tool) were either incomplete or incorrectly recorded. The MUST template also did not meet national guidance as some key sections were not included such as a body mass index calculation. We saw examples of patients who were refusing food and at risk of malnutrition which was causing skin integrity issues scoring zero meaning no intervention or dietetic plan. Staff told us they had had no MUST training for several months.
- There was variability with fluid balance charts which were not always up to date or totalled despite some of the patients having catheters where it is easier to record output. An adult fluid prescribing audit in November 2014 found most patients did not have appropriate fluid management plans or assessments.
- There was a lack of support for patients that required support to eat on Fielding and Hardy. Red trays were in place but we did not see these being used. We also saw patients served whilst they were asleep. However relatives told us patients were helped when needed and we observed patients were assisted to eat on the stroke wards.
- Staff were also not always identifiable that they were serving meals and they did not wear the green aprons allocated.
- There used to be a screen to display protected meal times but this was no longer in use which meant there was a risk that these times could be disturbed inappropriately.
- Meals were always tested to ensure they were at the correct temperature to be served but this was at the time they were put on the trolley, not at the time they were served which could be several minutes later.
- Meals were poorly presented in packs rather than on plates. Hot meals were served at the same time as cold puddings.

- There was varied feedback on the food with some stating it tasted microwaved or was 'tasteless'. There was also a lack of choice at lunchtime and the menu did not change much for long stay patients.
- Patients told us their specific dietary requirements were catered for such as lactose intolerance. However we also spoke with patients who told us there was little choice as they were on a soft food diet. Staff told us the contract for meals had gone through a number of different providers recently.
- Patients told us they sometimes did not get the food they ordered if they transferred between wards.
- Patients we spoke with and we observed always had something to drink.
- Snack boxes were available for patients being discharged from the discharge lounge in case they had a long trip or had no meal just before or just after discharge.
- We did not observe nursing staff actively assessing or promoting oral hygiene and mouth health in their patients. We did not see any trust guidelines or policies on patients' oral hygiene.

Patient outcomes

- Audit results were mostly better than the national average. The stroke units were graded overall A on the Sentinel Stroke National Audit Programme (SSNAP) with only discharge scoring lower than a B out of all the indicators. This rates the service in the top 15 stroke units in the country. Senior staff were proud of this service and felt this standard could be maintained without additional intervention from divisional level above what was already being delivered.
- NPH was slightly below the national average in two indicators on the Myocardial Ischaemia National Audit Project (MINAP) and around the average in the rest. There was a dedicated heart failure nurse for this audit.
- NPH was better than the national average in 11 areas in the National Diabetes Inpatient Audit (NaDIA) including medicine errors, prescription errors, insulin errors, admitted with foot disease, seen by the multidisciplinary team (MDT) within 24hrs, foot risk assessment in 24hrs, staff knowledge, overall satisfaction, and renal replacement therapy.
- There were tuberculosis audits including inputs into a national register and cohort reviews where summaries of individual cases were presented, discussed an analysed. Key indicators for cases reviewed in autumn 2014 showed they were at or better than target in ten indicators including known HIV status, offered directly observed therapy (DOT), one or more contacts identified, and completed treatments. However they were worse than target in eight including lost to follow up, and five or more contacts identified. This was slightly worse than spring and summer 2014. Actions were noted to try to improve their results.
- The average length of stay (ALOS) was higher than the national average in all specialities other than care of the elderly. They had a high length of stay in the emergency and acute wards with 27 patients staying over 14 days out of 100. Average length of stay on the AMUs was around 1.8 days with a target to transfer or discharge in 72 hours. However a high proportion were staying over this although staff felt these were normally patients that required a longer stay.
- However the divisional plan alleged cardiology had a better than average length of stay although they based this on an expected rate of 46.3 days which is not the national average comparable figure for this service. The opposite was the case with care of the elderly where the division felt they were performing worse but based on an average length of stay of 5 days which is much lower than the national average figure for this service.
- The Summary Hospital Level Mortality Indicator (SHMI) and Hospital standardised mortality ratio (HSMR) were both better than the national average although it had raised from Summer 2014. They were not a mortality outlier under any national indicator.
- The hospital also participated in a number of other local and national audits including asthma, NIV, pleural procedures, dementia, Parkinson's, fragility fractures, pneumonia, National Confidential Enquiry into Patient Outcome and Death (NCEPOD for pancreas, chronic obstructive pulmonary disease, human immunodeficiency virus (HIV), cardiac rhythm, consent, GP referrals, angioplasty, cardiac arrest, osteoporosis, blood transfusion, diverculitus, heart failure, echo, arthritis and VTE. However we did not see the results for these despite requesting them.
- We saw evidence of actions taken in response to national audits in some instances such as changes to patient records, improved monitoring procedures and improved checking procedures.

- Therapists had no outcome measures they could benchmark to as although they set goals for their patients using an approved mobility scoring tool, the end of their therapy pathway was after they were discharged from hospital.
- Audits of length of stay were conducted in the discharge lounge. Most patients stayed between 50 minutes and 2.5 hours. There was no set trust target or benchmark for this service.
- NPH readmissions within 48 hours were high at 12.1%.

Competent staff

- There was a good induction for junior doctors. They had two days corporate induction, two days local ward induction plus two days shadowing in different specialties. Doctors we spoke with told us this made them feel confident to start making patient decisions.
- They felt supported by their consultants and clinical educators where they were also able to participate in research and audits across different specialities.
- Student nurses felt well supported and were mentored with their mentors on shift with them nearly half of the time. However their lecturers did not work with them on shift and only saw students every ten weeks.
- Pharmacists had a corporate induction and assessment before being supernumerary for a few days before they went on shift.
- Appraisal rates were improving particularly Fielding, Dickens and Dryden with rates improving from around 50% to above 80%. However they were still low in a number of wards, although this was partly due to a high number of new starters. Staff that had appraisals told us they were useful and included discussion on professional development.
- Therapists told us they had their appraisals three weeks after their rotations and had a mid-term review.
- There were a range of nurse champions for different areas such as pressure ulcers, falls and other safety areas and we saw examples of study days for these staff.
- We were concerned by staff competency in a number of areas. Balloon pumps on CCU and Jenner wards were only used around four times a year which meant staff did not get much practice. Training on arterial lines included no assessment which meant it was not clear if staff were competent in practice after training.
- Nurses on the respiratory ward were not always respiratory trained but there were study days advertised for November 2015 and staff were resuscitation trained.
- There was a lack of competency for nurses on the stroke ward to treat general medical patients who were often outliers on the wards.
- However, appropriate competencies were in place on some wards. Haematology nurses were trained in NIV and chemotherapy. Dryden was able to take some level two patients and some nurses were critical care and NIV trained for these occasions. The band six and above nurses on the CCU were also advanced airway trained as they also cared for level two patients at times.
- There was a lack of an induction for agency staff including with equipment. Nothing was documented and no checklist was completed.
- There was a clinical educator for the AMU/AAUs but no practice development nurses.
- Mentorships were available for nurses and HCAs were able to undertake additional training such as taking bloods. Other training was advertised such as sepsis and alcohol withdrawal.
- Adaptation nurses worked as HCAs but also could conduct nurses duties under supervision. Staff we spoke with felt comfortable with this arrangement and the skill level the duties under supervision required of them. Overseas nurses were also buddied with each other and had a competency programme.

Multidisciplinary working

- Multidisciplinary (MDT) working took place on the stroke, RRU, diabetes and gastroenterology wards which included therapists, doctors, discharge coordinators and nurses. A midday MDT meeting occurred on the AMU/AAUs. We observed an MDT on the stroke units and they had a full variety of different staff groups including allied health professionals, discharge coordinators, doctors, nurses and psychologists. Each patient was fully discussed including treatment and discharge plans and this was fully documented.
- There was a multidisciplinary medicines safety forum across the trust. Medicines incidents were discussed at this forum, and learning was shared across pharmacy and nursing staff in a variety of ways (emails, handover meetings, medicines bulletins, information published on the intranet.)
- However MDT working was mixed elsewhere. The complex discharge team came to each ward weekly. However it was not a cross site team. There was an MDT for heart failure and cardiac arrhythmia patients but these only included doctors and nurses.

- NPH had a medicines support service. This was a referral system (especially for older patients) to a multi-disciplinary team including GPs, nurses and pharmacists to ensure care packages were in place for patients with complex medicines related problems. Evidence obtained which showed that this has reduced re-admission rates.
- Ward rounds were not MDT as they only included doctors and the nurse in charge. There was no AHPs or the nurse in charge of the patient in attendance. Pharmacists did a separate ward round reviewing drug charts, then approached the doctors directly afterwards. Therapists used to do a combined ward round but this had stopped a year ago.
- Phlebotomy conducted ward rounds on the AMU/AAUs two rounds a day including weekends.
- Tissue viability nurses had contact with each other at different sites and in the community.
- There was a lack of cross site working. Heads of Nursing had oversight cross site and we were given examples of practice that would be taken to Ealing from Northwick Park but not the other way round. Some senior staff acknowledged cross site working was in the early days.

Seven-day services

- Pharmacy was open Monday to Friday, 9am to 6pm and 9-2pm Saturdays with an out of hours on-call service on Sundays. However a few staff told us there was no pharmacy service on Sundays. No take to out (TTO) medicines could be dispensed at weekends.
- However, there will be an integration work plan to ensure that all pharmacy services across all sites were aligned in future. As part of this, there will be a consultation in the future to look at extending pharmacy opening hours equitably.
- There was mostly seven day working including imaging. There was appropriate AHP support on the AMU/AAUs with therapy support seven days a week. Dieticians were available at weekends and worked within a four hour response time to referrals. However there were no speech and language therapists (SALT) at weekends.
- Specialist nurses did not work weekends such as infection control.
- Ward rounds were conducted daily at weekends but sometimes they were conducted by a registrar rather than a consultant.

Access to information

- Discharge notes and summaries went to a patient's GP. The discharge summaries we reviewed were comprehensive with clear details on investigations undertaken, diagnosis and any further action or treatment needed.
- We saw examples of patients being given leaflets that explained their treatment such as oral anticoagulant therapy and heart failure.
- The pharmacists had access to summary care records.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- There was varied awareness of the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Some staff told us they had not been trained in MCA for some time and were not aware of DoLS. Others felt these areas were the duty of the doctors.
- We did see appropriate documentation when a patient was deprived of their liberty such as use of mittens including best interest assessments. However, some of the applications were not formally reviewed at a later date when the person may have regained their capacity or the restraint may no longer be in their best interest.
- We observed consent being obtained verbally when required.

Are medical care services caring?

Good

Medical inpatient services were caring in the majority. Observations we undertook showed patients were fully involved in their care with appropriate explanations and reassurances.

Patient feedback was predominantly positive. Interactions were caring, considerate and maintained privacy and dignity. Survey results were also positive although there were a few wards with low response rates.

Emotional support and reassurance was provided with support groups in place in some areas.

Compassionate care

- The Friends and Family test results showed most wards had over 95% of patients recommend the hospital with some wards scoring 100% recommending in some months. However, although some wards had high

response rates of over 65%, others were much lower at below 30% response rates although both scores and response rates were on an improving trend. This was due to both discharge coordinators and nurses giving the survey to patients on discharge although this was not available electronically.

- All the patients we spoke with had a positive experience. One patient told us "Staff always check on me, are kind and look after me." Another said "Staff are pleasant and caring'". Patients told us the attitude of staff was always positive and cheerful.
- Confidentiality was respected and maintained with curtains drawn during private conversations. The board round on Clarke ward maintained patients details as the board folded out into three so patient details were not displayed when it was not in use. When staff reviewed the board, they ensured it was not fully opened so only the relevant staff could see the information.
- We observed nursing staff being very attentive to patients and calling them by their preferred name. Patients told us call bells were answered promptly unless the ward was very busy and under staffed. Staff were watchful of patients who wanted to move around independently but could be a falls risk.
- Patients told us the wards were quiet enough for them to sleep.
- Intentional rounding took place and patients told us they appreciated being asked how they were and if they needed anything.

Understanding and involvement of patients and those close to them

- All the patients we spoke with knew why they had been admitted and knew their treatment plan including when they would be discharged. One patient told us 'They (doctors) ensure that he always understand what they were saying'.A few relatives told us they did not receive enough information and one patient felt their condition had not been diagnosed correctly. Otherwise, people we spoke with felt their treatment was explained in a way they could understand.
- Ward rounds were appropriate with interaction between the doctors and the patient explaining what they had reviewed. Staff were introduced to the patient at the beginning. Most of the patient note review was done outside of the bay so it did not seem doctors were talking about the patient without involving them.
- All the interactions we observed were in ways the patient could understand. Future plans were agreed with the patient such as follow up appointment dates and treatment plans. Patients were asked if they had any questions.
- There were also good interactions between allied health professionals and patients, with staff double checking patients had understood them.
- Patients had the choice of gender of staff to assist with personal care. However there was a lack of continuity of care on some wards where nurses in charge of patients often changed.
- We saw examples of staff involving patients in their personal care. One patient and their family had requested the family support the patient to eat, which was agreed.

Emotional support

- There was psychological and psychiatric support and staff were aware how to access this, including on the stroke ward. This was available out of hours.
- Family groups were available for families of patients who had had a stroke to meet on a weekly basis.
- We observed staff taking time with patients that required reassurance.

Are medical care services responsive?

Requires improvement

Medical services were not responsive to patient needs. There were significant challenges to patient flow with poor performance and delays at most points of the patient pathway such as admission, transfer from AAU/AMU and discharge. In addition, although capacity was one of the main factors, how the situation was being handled could be making the situation worse such as how bed meetings were conducted, and how the new AMU/AAU was being brought in.

The environment was not responsive to patient needs with space, age and clutter a significant problem in many wards.

However, some complex needs were being well supported and there was learning from complaints evident.

Medical care (including older people's care)

Service planning and delivery to meet the needs of local people

- AMU/AAUs were split into two wards, one for the most acute patients with monitoring (Dryden) and the other was for short stay and less acute patients (Dickens).
- The respiratory ward could only take patients who were stable on non-invasive ventilation (NIV), either as step down from the HDUs or admitted from home. This meant that there was a lack of step down facilities for patients recovering from tracheotomies or required weaning off ventilation.
- There was a high number of alcohol related gastroenterology patients on Byrd ward with around seven per day. This was much higher than other hospitals so the hospital required a high provision for these types of patients.
- There was one alcohol liaison nurse employed by the trust and they were supported by similar nurses from the local mental health trust.
- There were a number of issues with the environment and facilities that were not responsive to patient needs.For example, patients, family and friends were unhappy with car parking provision and prices. Many patients were not aware of discounted parking charges.
- The Coronary Care Unit (CCU) was mixed sex despite having some patients who did not need level two care (those that require at least one organ supported) admitted. Staff felt this was within guidance due to being a CCU. This meant the hospital were not declaring mixed sex breaches in this instance.
- There was a lack of temperature control on the wards which meant they could be too hot or too cold depending on the time of year.
- Staff were unhappy at the size of some of their staff rooms as they were small and cramped.
- There was a lack of storage space on the stroke units meaning areas were cluttered with equipment in corridors and the day room.
- There was a lack of space on Defoe and Clarke, particularly on a Thursday as two ward rounds were conducted that day which included over 20 members of staff in one space. Clarke and Byrd were particularly old environments and staff told us the trust were not investing in the wards as they were due to move.
- There was a lack of computers on Dickens and Dryden for test results with some doctors having to wait 15 minutes to access one. There was also a lack of wifi access on some wards. Otherwise staff were happy with the IT facilities.
- However some parts of the environment were more responsive to patient needs. The discharge lounge could take both mobile and bed based patients up to 15 patients and there were facilities for hot meals and drinks whilst patients waited. Entertainment facilities such as TVs and radio were also available. It also had a dedicated porter. However, one patient told us they required a hoist to go to the toilet and this facility was not available in the lounge and some patients said they waited up to three hours for transport.
- Relatives were allowed to stay overnight in quiet rooms on the wards and were brought drinks during the night.
- All wards had a toilet per bay and toilets were gender based.

Access and flow

- Flow across, through and out of medical wards was restricted. We observed many patients had waited over 12 hours to be admitted either to one of the AMUs or a specialist ward from A&E.
- Although there were no follow up clinics from an AMU stay, patients could be booked into the ambulatory care unit to be follow up if necessary such as test results. However some doctors seemed unaware of this service.
- Transfers out of the AAU/AMUs onto specialist medical wards were constantly delayed with a high number of patients often waiting over 48 hours to be transferred (17% in July 2015). Capacity to admit from the AAU/AMU was of most concern in the care of the elderly wards, James, Byrd and stroke wards.
- Bed occupancy was mostly above 95% when a figure above 85% is considered to negatively impact on patient care. There was a general lack of bed capacity on the site. Staff told us particular concerns were cardiac patients. There was a lack of haematology beds as Kingsley only had capacity to take transcobalamin (TCI) patients whereas others were outlying on other medical wards.
- The new AMU/AAU would add a total bed capacity of a minimum 48 beds and four trolleys whereas an external audit found there was a need for an additional 100 beds at the hospital. However the cumulative additional beds

would be due to relocating two wards. If the original wards were kept open, it would mean 63 additional beds would be open but no decision had been made at the time of our inspection.

- Although a new AMU/AAU was being built that was due to be ready by November 2015, we were concerned about how the rest of the services would be affected including on staffing. We received a number of different plans about how Dickens and Dryden would be used in the future, with some stating there would be a fragility ward, whilst others said they would continue to be AMU/AAUs. However some staff would be taken from these wards to the new AMU so staffing ratios for the current acuity would not be able to be maintained.
- The hospital declared 33 medical outlying patients in June 2015. However these were medical patients that were on surgical wards. They were not declaring patients that were on the incorrect medical ward, which we found was occurring much more frequently such as general medical patients on Defoe and the stroke units. In addition, senior staff seemed to feel the stroke unit beds were protected from caring for outliers. However outlying patients acuity and dependency was generally lower so it was easier to look after them.
- We observed two bed meetings that vastly contrasted. The first we observed had senior operational staff in attendance and attendees from all but one ward. Patient moves from A&E were dealt with individually to ensure appropriate allocations both to specialist wards and those being discharged. Support arrangements for discharge such as transport were also discussed with transport in attendance.
- However, the second meeting had very few senior staff in attendance and many wards had no attendees or attended late which meant there was not a full picture of what beds were available. In addition, only patients waiting over 12 hours to be admitted were flagged, not those coming up to 12 hours.
- There was a safety huddle at each bed meeting but one was run by a head of nursing whereas the other was run by the site team. In addition, only two matrons were present at the second safety huddle. Dashboards from these meetings consistently showed that there were A&E breaches at NPH but there was spare bed capacity at Ealing that was not being utilised. In addition, the dashboards we were sent were not clear what speciality capacity issues were within, although this could be noted.
- The trust did not provide us with data to show how many patient moves occurred despite requesting this.
- A high number of discharges occurred out of hours with 18% occurring after 7.00pm and this was across all wards. Transfers of patients on CCU were sometimes late due to transfers or admissions of level two patients at night. A target to discharge by 10am was in place but this was rarely met. Over 500 transfers were delayed a month.
- Each patient was due to have an estimated discharge date (EDD) although these were not always in place. However staff told us some of the EDDs allocated by the AMU/AAUs were unrealistic and had to be reviewed on the specialist ward.
- Physios told us EDDs were often not met due to patients not being physically fit. Some senior staff felt there were issues with the time it took to complete assessments and a lack of nursing and care homes in the area. There was a lack of social care placements to deal with the under 65 year old alcohol related mental health patients the hospital treated which meant discharge was difficult.
- There were delays with discharge summaries and as these were constantly required, this sometimes pulled doctors off ward rounds. Staff told us they took between 30 and 60 minutes to complete as there was no cut and paste facility. Therefore staff were asking these to be done the day before discharge if a patient was only awaiting results so to prevent a delay.
- Most of the wards had a dedicated discharge coordinator who referred patients to social services and community therapists. However, they were not always a nurse so still required the nurses and doctors to complete the relevant paperwork and did not work weekends. There was due to be criteria led discharge with junior doctors to improve discharge planning so forms were completed 24 to 48 hours in advance and use of an electronic system to flag patients, which was already in place at Ealing Hospital.
- There were some delays with dispensing medicines as the pharmacy had no robot dispensing due to lack of space for this facility. Some patients waited over four hours for to take home medicines (TTOs). Staff told us TTOs were mostly requested for different patients at the same time but this was unavoidable, and pharmacy were responsive in ensuring all patients that staff knew

required a TTO for discharge was recorded in the morning. The average waiting time for pharmacy dispensed TTO's had decreased from April 2014 (129 minutes) to August 2015 (65 minutes).

- Nurses working on the AAU/AMUs had access to 'TTO pre-packed medicines that could be given to patients on discharge when the pharmacy department was closed, however discharges were usually planned so that discharge medicines were not usually required out of hours.
- There was a discharge lounge but it was only open during the week. However patients were able to use the discharge lounge if they were only awaiting TTOs or had transport booked and checklists were completed by the nurses to ensure a patient could be discharged from the lounge.
- There was a backlog of angiograms. Junior doctors reported there to be long delays with echocardiograms at NPH although plans were in place to introduce an additional catheter lab with doctor support.
- Pathways through admission were appropriately set up. There was an appropriate patient allocation and discussion on the AMU wards. Consultants from different specialities were in attendance where each patient on AMU short stay were discussed and allocated three times a day.
- There was follow up of patients with infectious diseases.
- There was an appropriate Ebola pathway and although the infectious diseases ward was due to move, a new pathway had been arranged that would also be appropriate and had been assessed by infection control.
- Medicine met the referral to treatment for admitted patients target of 90% other than in cardiology and general medicine. This meant they varied between above and below the England average.

Meeting people's individual needs

- Staff were aware of the learning disability nurse and support arrangements for those patients was appropriate such as use of easy read or picture cards for communicating. An electronic flagging system was in place and there were ward learning disability champions. We also saw learning disability passports in use though some had been brought from their home. However other staff were not aware of the tools available to them and not all patients were flagged on admission.
- Translator services were available and these were used if the patient had capacity and there was need for consent. Otherwise, there was a use of visual prompts, staff who could speak the language or relatives to communicate when necessary.
- NPH was failing the dementia Commissioning for Quality and Innovation (CQUIN) although it was better than Ealing (dementia screening as 77.8% compliance and dementia assessment at 93.7% compliance), due to being able to electronically record. Senior staff felt there was a lack of resource in meeting dementia needs particularly as the CQUIN payments did not go back into dementia care.
- Dementia nurses were available and saw all patients who were admitted that lived with dementia. However, some staff told us they were not specifically identifiable on admission, only on handover and they had no specific dementia training. Some patients living with dementia had no support plan such as 'this is me' or 'forget me not' or other type of passport.
- We were not provided with information on how medical services met people's needs if they were blind or deaf.

Learning from complaints and concerns

- Inpatient medical services received very few formal complaints and a high number were dealt with informally. There had been 22 complaints across inpatient wards last year, mostly on the AAU/AMUs although the divisional dashboard showed medical services received around 12 a month. Most complaints were about communication, noise and light on the AMUs and car parking.
- The hospital wide response rate within 28 days was 73% but we were told medicine was worse than this.
- There were no complaints leaflets in a number of wards.
- We reviewed four complaints responses and all contained a detailed response to the concerns, appropriate apologies and actions the trust would take to improve. Although some of the actions were not as strong as they could have been such as reminders to staff when there could have been a wider system issue, we saw examples of complaints being learnt from including additional drink provision and choices on wards.

Are medical care services well-led?

Medical care (including older people's care)

Requires improvement

Medical services were not well-led. Although there was a vision and strategy for the services provided, this were not embedded with staff on the floor and were very focused on the emergency and acute pathway rather than other areas, despite department plans being developed.

There was a clear governance structure but it was not being fully utilised with key leadership positions not in post and full monitoring of performance was not in place. Cross site working was in its infancy in most specialities.

There was a supportive leadership at ward and department level but there was an impression the divisional leadership were acute pathway focused. There were also some unclear reporting lines in care of the elderly.

The culture of the service was mostly positive but some silo working was apparent. There was a high workload which staff felt was causing a high staff turnover.

There was some staff and public engagement but this was limited and had not proved fully effective.

Some good innovative practice was in place in some services although we found results of these were not as good when practically applied. Sustainability due to finances was a concern.

Vision and strategy for this service

- There was a divisional plan in place for 2015/16 which included improved integration and multi-disciplinary working. Most other plans within inpatients involved the new modular unit which would house the new AMU/AAU and Clarke ward. However there was varied awareness by senior staff of the divisional or trust wide strategic direction despite this plan being in place.
- There was an awareness of the plans for the new modular unit AMU/AAU but staff were unclear on the future of Dickens ward, with various plans suggested including a fragility unit or keeping Dickens as a short stay AMU. Senior staff told us they had informed staff but the operational policy had not been ratified for the unit. Staff told us some of them were going to the new AMU but senior staff said rotations between the new and current AMUs had been offered. Staff in other specialities were unaware of pathway arrangements once the new AMU was open.
- Respiratory had a clear vision to develop specialisation such as endobronchial ultrasound (EBUS), TB management pathway alignment, pleural services, sleep service and more NIV competence although the timescales for this were not known and there was a lack of joining this vision up between NPH and Ealing Hospital.
- There were department plans although some of these were not drafted. Care of the elderly staff had plans to improve dementia care with a new dedicated matron, and reduce falls with anti-falls equipment. Divisional staff knew care of the elderly needed to have more focused emphasis.

Governance, risk management and quality measurement

- Medicine had a divisional leadership team comprising of a general manager, clinical director and director of nursing. Underneath them were departments for specialist medicine (cardiology, respiratory, neurology, infectious diseases, dermatology, TB, lung, rheumatology, endocrinology, nephrology, and haematology), ambulatory and acute medicine, and stroke and care of the elderly. These each had managers, and heads of nursing. They were due to have clinical leads but these were not in place during our inspection. However there were clinical leads for each speciality at each site.
- There was mixed governance over Byrd ward as the patients were medical and had medical doctors but the matron reported to a surgical head of nursing. However, staff said this arrangement still worked although specialist medicine would be a more appropriate area.
- A divisional scorecard was in place that reviewed key performance indicators such as length of stay, readmissions, activity, patient harms and referral to treatment targets. However although these were reviewed on a monthly basis, we saw very little actions to improve areas of poor performance.
- There were ward specific dashboards on equipment, hand hygiene, catheters, cannulas, MRSA, pressure ulcers, medicines, NEWS, nutrition, resus trolleys, CDs, blood sugar, complaints, patient feedback and falls.

Medical care (including older people's care)

- A risk register was in place that was up to date which included some of our concerns such as bed capacity, staffing, and temperature controls plus actions were recorded to overcome these risks. However, many areas of our concerns were not included such as nutrition, discharge, and the environment. In addition, no dates for completing actions were recorded and some risks had been on the register for over two years.
- There was a lack of awareness of local risks but there was an awareness of trust wide risks such as bed capacity although floor staff were unaware of there being a divisional risk register.
- There was a lack of cross site working and awareness at department level. Divisional clinical governance meetings had just started but only involved divisional staff and not department or below level plus they were still working on terms of reference in their latest minutes. The divisional plan targeted December 2015 for a fully integrated divisional governance though we note that the trust had merged a year ago and had been planning to merge for a number of years.
- Ward managers told us there were clinical governance meetings where incidents were discussed but we did not receive minutes of these at a department level in most specialities. Some senior staff acknowledged governance had weakened since the merger.
- There were AMU clinical governance meetings but these purely discussed audits and incidents only with very few or unclear actions recorded. Safety thermometer performance was not discussed if the presenter was not in attendance.
- Link nurses for areas such as pressure ulcers also disseminated learning. However there were no themes each month to target weak areas of performance or safety huddles at ward level. Minutes of meetings we reviewed included discussion on appraisals, sickness, doctor change overs, shifts and never events. These minutes were emailed to staff and in the staff rooms.
- Care of the elderly staff said there was no clinical governance at NPH although there were some performance indicators.
- Diabetes did have team meetings involving cross site staff but focus was on immediate issues such as changes to service or upcoming performance indicators such as commissioned activity, rather than a structured agenda on incidents, risk or performance.
- Pharmacists had a monthly medicine safety meeting which included topics of high risk. Recently this had included anti-epileptic medicines.
- Senior staff on the infectious diseases ward said they reviewed performance on a weekly basis with their heads of nursing including incidents.
- Cardiology held directorate meetings which discussed cross site changes to services but not clinical governance issues.

Leadership of service

- Feedback from staff was that there was good management support and leadership at ward and department level. Staff felt there was support from the divisional leadership for the emergency and acute pathway but not other departments with some areas feeling marginalised.
- We were concerned senior managers were not worried about the effect on staffing levels that taking out at least 72 staff to the new AMU/AAU would have on the rest of the inpatient medical wards. This was especially considering the new staff recruited for the new AMU had been incorporated into the existing ward staff establishment. However the trust told us that managers had instigated an allocation of staff who had been recruited specifically for the AAU to existing vacancies as the date for the build completion had been deferred. These vacancies were actively being recruited to throughout this process and therefore, in the trust's opinion,the transfer of the nurses to AAU did not affect the level of vacancies nor the on-going recruitment process.
- There was varied feedback on the visibility of the executive team with some staff stating they had seen separate members of the executive team whereas others had not and didn't know who was in which role. This was despite the executive team stating they did walkabouts and staff forums.
- Physiotherapy staff felt their senior support was reactive rather than proactive although they had meetings once a month.
- Some staff were unclear of their reporting lines in Care of the Elderly as the head of nursing was based at Ealing and the divisional director of nursing was acting down at NPH. It also meant some senior staff were unclear where their role's oversight should be.
- There were no clinical leads at a department level. Senior staff acknowledged these had been delayed.

Medical care (including older people's care)

Culture within the service

- There was a high turnover of staff on the wards apart from on Dryden.
- Sickness was high on Dickens at 7% and some staff told us this was due to the increased workload since other A&Es had closed in north west London. However overall sickness in medicine was low at 2.7%
- There was some silo working and a tension that acute medicine had been prioritised over other specialities. This was despite the divisional plan prioritising clinical integration into care of the elderly, cardiology and respiratory.
- There was a good culture in the allied health professionals such as pharmacists and therapists.
- Staff were happy with escalating concerns.

Public engagement

- Each ward had a 'you said, we did' board which showed an example of feedback they had received and what they had done about it. However the descriptions were sometimes vague with some just stating compliments that had been received. Others had 'discussed at team meeting' rather than any specific action that had been taken.
- A comments board was available in the discharge lounge and all the comments we saw were positive.

Staff engagement

- Some staff were concerned about the effect the new AMU unit would have and this was causing anxiety with staff. Senior staff told us they had verbally told staff about the plans and the implications but there was no paper based consultation that had occurred. Otherwise staff felt engaged in the trust.
- There were weekly bulletins from the chief executive on a weekly basis and staff did acknowledge there were walk-rounds and forums but did not feel they were regular.
- Staff had a briefing at handover to give updates but this was not formalised.

Innovation, improvement and sustainability

- There had been research projects into falls bundles, stroke trials and cross site working was good in research. However, the bundles we saw were not patient individualised.
- There were good plans to improve the alcohol liaison service. This included a new day unit once the gastroenterology ward moved so they could detox medically fit patients without effecting the flow on the ward.
- There was a lack of specialist respiratory services which we were concerned would impact on recruitment. Staff told us this was recognised in the divisional strategy but implementation of specialist services was still not moving forward despite the staff numbers enabling them to do so. There was no integration of respiratory services across the trust.
- Some senior staff felt there was no investment in care of the elderly in A&E.
- There was due to be a project called 'Breaking the cycle' which was to review and reconfigure services to improve the emergency pathway.
- The division was not on target to meet its cost improvement programme particularly regarding pay due to a higher amount of patients needing 1:1 care and agency spend. We were concerned considering the recruitment trajectory and expected activity, this situation was unlikely to improve in the near future.

Surgery

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

Information about the service

There were 29,473 surgical procedures carried out during the period from January to December 2014. Emergency surgery accounted for 56% of this activity, elective surgery 27% and 17% day surgery. General surgery was the main specialty at 39%, followed by urology, which accounted for 16%, ear nose and throat (ENT), at 10% and all other surgery types contributed 35%.

Northwick Park is a designated centre for urological procedures. There is a full range of minimally invasive (key hole) surgery for both benign and malignant conditions, such as bladder, prostate and kidney cancers and benign kidney diseases. The Theatre Admissions Unit (TAU) is a purpose built unit providingelective day case and short stay surgical servicesfor adults.

The vascular surgery department provides diagnosis and management of carotid disease, aneurysmal disease, peripheral arterial disease, critical ischemia of the leg and venous disease. The vascular team works closely with interventional radiology and have an active endovascular programme for the management of abdominal aortic aneurysms. They also offer a service for hyperhidrosis lymphoedema, thoracic outlet syndrome and vasospastic disorders (e.g. Raynaud's disease). A consultant-led regional vascular service for emergencies is available, 24 hours a day, 365 days a year. There is a dedicated vascular/ endovascular theatre suite with one arterial list running every day.

Diseases affecting the face, jaw, mouth, teeth, neck, salivary glands and skin were treated under the maxillofacial and oral services. A full range of elective (non-emergency) and trauma (emergency) services are provided at the location.

There are eleven operating theatres in use, a theatre assessment unit (TAU), pre-assessment and discharge lounge. Surgical wards included; Edison Ward (44 beds), providing vascular and general surgery, Evelyn (31 beds), the trauma and orthopaedic ward, Fletcher (27 beds), encompassing the surgical assessment unit and short stay surgery, Gray Ward (25 beds), which is a regional unit for north west London for head and neck and maxillofacial surgery; and Dowland Ward, which has 16 beds for urology patients.

We visited all of the above wardswhere we spoke with 52 staff including surgeons, nurses, allied health professionals such as phyio and occupational therapists, pharmacists, and administrative and ancillary staff, and 20 patients. We made observations and reviewed 17 patient records. We reviewed information provided by the trust prior to and during the inspection such as policies, procedures and audits, and we considered feedback from staff duringfocus group meetings held before the onsite inspection.

Surgery

Summary of findings

The reporting of incidents was not fully embedded in practice across all staff groups. Incident type was not always categorised correctly and there was a lack of awareness of outcomes from incident investigations , including never events.

There was a lack of expert support from consultant radiologists at weekends, which impacted on the accuracy of clinical diagnosis being achieved. Risks related to patient safety and service delivery had not always been identified and agreed timelines for resolution had not always been identified.

There was a lack of formalised admissions pathways for some surgical patients, including those with head injuries. The surgical wards had not been developed to address the needs of individuals living with dementia.

Patient surgical outcomes were monitored through audit and required improvements had been noted for hip fracture patients and those having an emergency laparotomy. Referral to treatment times were not being met in some surgical specialties. Theatres were not always effectively utilised and operating sessions started and finished later than planned, which impacted on patient discharges.

There was lack of assurance that staff had received Mental Capacity or Deprivation of Liberty Safeguard training.

Surgical staff reported a lack of support and engagement at trust board level.

The development of the surgical directorate strategic aims was in progress and would need time to be embedded into practice.

There had been limited opportunities for patients to contribute to the running of the surgical service, although they were able to feed back on their experiences.

Surgical directorate leaders understood their roles and responsibilities and the governance arrangements were set out to facilitate the monitoring of identified risks, reported safety concerns, patient outcomes and effectiveness of the service.

Staff demonstrated a commitment to delivering high standards across the surgical service and there was a culture of openness and transparency. The ward and theatre staff reported favourably on their immediate line managers, their approachability and support and reported being valued and respected

Staff had the necessary skills and experience to ensure safe and effective patient outcomes and were supported appropriately.

Patients needs were assessed, treated and cared for in line with professional guidance, under the leadership of consultants. The multidisciplinary team and specialists supported the delivery of treatment and care. Patients reported positively with regard to the quality and standards of care they received from staff.

Where complaints were raised, these were investigated and responded to and where improvements were identified, these were communicated to staff.

Surgery

Are surgery services safe?

Inadequate

We rated safety in surgery at Northwick Park as inadequate.

Despite the availability ofeffective processes for reporting, investigating and learning from incidents, surgical staff were not always reporting incidents and openly told us.There was a risk that incidents were not made aware to the wider team and that opportunity to learn from events was not taking place.

A number oftheatre staff did not have an insight around incidents that had been reported, including the learning from the investigation and never events. We found little or no evidence of shared learning from those incidents that were reported.

We noted that not all of theactions associated with the WHO surgicalsafety checklistas set out in trust procedures were being fully completed.

Lack of expert support from consultant radiologists at weekends impacted on the accuracy of clinical diagnosis.

Lack of nurses on Evelyn Ward at night on occasion impacted on nurses taking responsibility for a higher number of patients than recommended. Staff shift arrangements took account of skill mix and shift handovers were well managed, with key issues identified, recorded and action to ensure patients who were unwell were monitored and supported.

Staff were open and honest with people when things did not go as expected. Consultants told us that safety concerns had been escalated with no resulting action taken.

Clinical staff adhered to infection prevention and control best practices and followed professional guidance around medicines. The environment in which patients received treatment and caredid not in itselfinhibit safepracticeand there was sufficient equipment to support their needs. Staff received mandatory safety training in order to ensure the delivery of safe patient care.

Incidents

- The trust reported fewer incidents per 100 admissions through the National Reporting and Learning System than the England average (7.1 per 100 against 8.4). The criteria within the Serious Incident Framework describes the general circumstance in which providers and commissioners should expect serious incidents to be reported. There were 17 serious incidents (SIs) reported in surgical services, five of which related to pressure ulcers. A process to review such incidents and to feedback the learning to staff was actively used.
- Nursing and medical staff had a full awareness of the processes to follow in order to report adverse incidents or concerns. Nursing and theatre staff who spoke with us understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally in order that they could be investigated and acted upon.
- However, surgical consultants and othergrades of medical staff told us they did not routinely complete incident reports for issues or concerns as the forms were said to be “too laborious” and nothing was done to change the problems highlighted. They cited non-reported examples of misdiagnosis related to lack of consultant radiologist availability to review scans at weekends. These issues had been highlighted in Mortality and Morbidity (M&M) meetings and logged. However, consultantsindicated that patients were being unsafely treated and despite escalating this, told us there had been no change. They added the M&M meetings were not minuted as there was inadequate administrative support, (two admin staff for nine surgeons.) These issues had not been identified on the surgical risk register.
- We reviewed the minutes of theJoint Surgical and Anaesthetic Morbidity and Mortality Meeting held on 29 September 2015. These contained evidence indicative that incidents were not always reported via the Datix system. For example, the minutes stated all radiology addendum reports that had an effect on a patient’s outcome needed to be reported on Datix and highlighted in order to be logged as evidence. We noted that two patients with delayed diagnosis due to misdiagnosis on an initial CT should have been included as evidence for discussion with radiology regarding addendums.
- A consultanttold us there was a strong culture of patient safety in theatres, with a newly published safety manual, created following engagement with relevant stakeholders. However, whilst we were in theatres, we were made aware of two separate incidents, one of

which related to a patient not having been given their pre-operative preparation and therefore resulted in them having to be returned to the ward. The second related to a patient who had not had their consent completed for the whole of the required procedure, as a result, the patient only had part of their treatment. We asked for information to see if these two incidentshad been formally reported via the Datix system. However the information provided to us, did not identify either of these incidents despite a number of days passing since the incidents.

- We noted from a range of surgery clinical governance minutes and weekly meeting minutesprovided to us that mortality and morbidity (M&M) reviews wereheld within the different surgical specialties. Discussions included a review of specific patients, outcomes and lessons learned. Surgical mortality and morbidity reviews fed into service improvement, for example, we noted the arrangements around radiology identified a system problem, which pertained to the referral and on-call interventional communications.
- We were told by nursing staff that reportedincidents were reviewed, so that contributory factors could be identified and acted upon. Root cause analysis (RCA) was said by ward staff to be used for more serious incident reviews. Nursing staff confirmed the reporting process enabled the staff member who entered the incident to receive feedback via the Datix system. Feedback to the wider group was said by staff to take place as necessary and included learning from RCA at shift handover and in team meetings, which we were told were minuted. We asked to see minutes from team meetings on Evelyn Ward and with the exception of one, the minutes preceded 2010. The notes from January 2015 meeting had not been formally presented and did not make it clear to the reader the nature and level of discussion around incidents or shared learning.
- We asked staff in theatres about RCA and learning from incidents and were directed to a file with minutes therein; however, these minutes did not contain any information about shared learning.
- Two never events had been reported to have occurred between the period of August 2014 and July 2015, one of which related to the wrong blood type given to a patient and one wrong site surgery. “Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.” Staff on wards were able to describe the learning from a review of this event and how training had re-informed correct practice. An anaesthetist who spoke with us was aware of the never events but two theatre staff were not aware of the never events, and a third member of theatre staff told us there had not been any never events in the previous six years.
- We found, when reviewing information provided, the investigative process concluded with the sharing of information with the relevant patient family, individual staff members having a copy of the formal report and cascade of information across inpatients facilities.
- Staff were open and honest with relevant patients or relatives when serious incidents had occurred. We reviewed written correspondence sent out to relatives and noted an invitation to attend a meeting with relevant staff in order to be appraised of the outcome of a SI investigation. We noted a statement of apology had been included within written letters.
- From our discussions with a wide range of nursing and theatre staff, there was a good understanding about openness and honesty with people when things had gone wrong. Nursing staff had a variable level of awareness of the term ‘Duty of Candour’. This sets out the premise that as soon as reasonably practicable, after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- Safety goals had been set with respect to a range of indicators. This included, for example, safety around medicines, the completion of patient safety checks, staffing levels and safety related training. Targets were rated using a traffic light system of red, amber and green, and a performance dashboard was produced for each area. This enabled staff to see the monthly performance and cumulative results over time, year to date.

Safety thermometer

- Prevalence rates for pressure ulcers at grades two, three and four, patient falls and catheter related urinary tract infections had remained similar over the time period of June 2014 to June 2015 at Northwick Park Hospital(NPH).
- The NHS Safety Thermometer scheme had been used to collect local data on specific measures related to patient harm and 'harm free' care. Data was collected

on a single day each month to indicate performance in key safety areas, such as hospital acquired pressure ulcers, patient falls and urinary tract infections related to having a urinary catheter. This data was collected electronically and a report produced for each area, with results displayed on wards.

- We observed results on Evelyn Ward and noted in September there were no Venous Thromboembolisms (VTE), catheter related urinary tract infections or patients falls; however, they had reported two patients who had developed a pressure ulcer in the month. Results for Fletcher Ward indicated no infections, VTE or falls in the month and two patient falls overall year to date.On Gray Ward there had 15 patient falls year to date, none of which resulted in serious incident classification. They had one hospital acquired pressure ulcer, which was not classified as avoidable.
- Staff used appropriate measures, including care bundlesto manage risks to patient's acquiring pressure ulcers and minimising the risk of falls.

Cleanliness, infection control and hygiene

- We observed that there were dedicated staff for cleaning ward areas and they were supplied with nationally recognised colour coded cleaning equipment, which allowed them to follow best practice in respect to minimising cross contamination. Domestic staff cleaned theatresat nights. Clinical staff cleaned operating theatres in between cases.
- Guidance as to the required cleaning duties and responsibilities were displayed on wards.
- Operating theatres, pre-assessment and wards were found to be clean on inspection. Within theatres, there were separate clean preparation areas and facilities for removing used instruments from the operating room ready for collection for re-processing by the external decontamination service.
- Cleaning audits for theatres undertaken inApril and May 2015 indicated a high level of compliance (98%). Where scores were less then expected, the issue was identified and communicatedvia the monitoring tool.
- We noted there were facilities available on wards to isolate patients who had a communicable infection. Signage was in place to alert staff and visitors of precautions to be taken. On Edison Ward we noted a member of catering staff did not follow the correct precautions, including the decontamination of their hands. On discussion with this person and another member of catering staff, we were told they had received infection control training. They said they did not go into the isolation rooms and washed their hands on return to the kitchen. Hand sanitiser gelwas said to be used when going from room to room.
- Patients commented positively on the standards of cleanliness and frequent attention to cleaning by domestic staff.
- We reviewed a number of infection control policies and found that the information contained therein provided up to date and reliable information to support staff in the prevention and protection of people from a healthcare-associated infection. We observed staff and noted they followed safe practices as outlined in the respective policies, such as hand washing and wearing personal protective equipment (PPE). This included theatre staff wearing a protective over gown when they left the department; however, they did not always tie up the gown and therefore the theatre clothing was not well protected. In addition, we observed that staff had ensured items of equipment used by patients, such as commodes, blood pressure cuffs and infusion devices were clean and labelled as such.
- Nursing staff confirmed that there were link nurses for infection control and that these individuals had the responsibility for attending meetings and cascading training to staff. The monitoring of staff compliance with infection prevention and control standards was also part of their role. This included hand hygiene compliance. We saw by way of example, the quality board presented on Gray Ward hand hygiene compliance rate of 89% year to date. For Evelyn Ward the rate of adherence with hand hygiene practices was 95%.
- There was access to adequate hand washing facilities and decontamination hand gel was readily available at the point of care and in all areas where patients care was delivered. We made observations of staff practices with regards to adherence to decontaminating their hands immediately before and after every episode of direct patient contact or care. Nursing, medical and allied health professionals were observed to wash their hands or use hand gel during the course of their activities.
- We witnessed staff adhering to bare below the elbow dress code.
- Patients records indicated they had been screened for Meticillin-Resistant Staphylococcus Aureus (MRSA)

during pre-assessment or as soon after admission as possible, where they had been admitted as an emergency. We noted from patient safety and quality monitoring that MRSA screening was reviewed on an on-going basis. Results for Gray and Evelyn Wards indicated MRSA screening to be 100% year to date.

- Patients received information in the pre-operative phase about showering and hair removal, hand jewellery, artificial nails and nail polish. Checks were made as part of the patient's preparation for theatre and prior to escorting to theatre. Where specific preparation was required for a surgical procedure, information was provided by staff.
- Theatre staff were observed to follow best practice during each stage of the intraoperative phase including hand decontamination, application of surgical drapes, sterile gowns, gloves antiseptic skin preparation.
- Patient care records reviewed by us demonstrated where staff had followed the specified procedures necessary for the safe insertion and maintenance of intravenous devices. Staff had recorded when devices had been inserted, monitored the site of location and recorded when they had been removed. On-going compliance with the safety indicator related to peripheral cannulas was noted to be 100% for Evelyn and Gray Wards year to date.

Environment and equipment

- Surgical wards ranged in size and layout but were noted to be set out in a manner which ensured people were safe. Wards were accessed by staff using a swipe card or buzzing through to the reception in thecase of visitors.
- The operating theatre department had 11 separate theatres, with associated anaesthetic rooms and the required separate clean preparation and dirty areas. On the first day of our visit, one theatre was not in use as a result of a fault with the air conditioning. There were four theatres that had Laminar flow ultra clean ventilation.
- The recovery area of theatreshad 15 spaces, with access to equipment, medicines, clean and waste disposal areas.
- The Theatre Admissions Unit (TAU) had 14 beds with sufficient access to toilets. There were two side rooms with en-suite facilities.
- We found the arrangements for managing different types of domestic and clinical waste and clinical specimens kept people safe. Hoists had evidence of safety checks having been completed.
- Surgical equipment including resuscitation and anaesthetic equipment was noted to be readily available and was fit for purpose. Most equipment had been checked in line with professional guidance. However, we noted the epidural trolleys, which were to be cleaned and checked every week had not been checked for two weeks. There was no formal log with these items to record such checks.
- Single use equipment was available on wards and in theatres. We checked a sample of these on wards and found them to be in date.
- Checks of essential anaesthetic theatre equipment had been undertaken and there was access to emergency items of equipment. There was sufficient supply of drapes, gowns, suction and other equipment items used for the safety of patients in theatres.
- Sterile services for surgical instrumentation were provided off site. Comments from different staff were inconsistent with respect to the quality of service. A band seven nursetold us there had not been any problems; however, the senior manager told us instruments were sometimes missing off sets, resulting in additional sets having to be open. This had associated cost implications. We noted this issue had been identified on the surgical risk register.

Medicines

- Information reviewed by us and discussion with staff confirmed there were pharmacists and pharmacy technicians presence on surgical wards Monday to Friday during day time hours. Staff confirmed the medicines charts were reviewed daily by pharmacy staff and, in particular, new admissions and any patient who was going home, in order that required take home medication was prepared.
- Pharmacists visited the wards during the weekdays and we saw evidence on the drug charts that drug histories were completed for each patient and pharmacy interventions noted. A pharmacist explained how they undertook reporting on a drug of the month, which included checks on errors such as those related to prescribing.
- We observed a range of information was available to staff related to safe management of medicines. This

included drug protocols and policies, such as an intravenous drug policy and cytotoxic drug policy. Staff had access to national formularies and safety alerts concerning medicines had been displayed.

- We checked the process for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines on wards and in theatres. The arrangements for managing medicines and medical gases ensured people were kept safe. Medicines were stored safely in lockable cabinets, which were secured to a wall when not in use. Medicines cupboards were locked and only accessible to designated staff. Emergency medicines were accessible in theatres.
- Checks on fridge temperatures had, in general, been carried out in theatres and on wards. On Evelyn Ward, we noted four dates in September 2015 where staff had not indicated any checks having been undertaken.
- Medicines used in the anaesthetic room and theatres were seen to be prepared safely, with labels attached to syringes and checks were undertaken prior to administration. Medicines given to patients had been recorded on anaesthetic charts and prescription records in the theatre area. There was access to emergency drugs.
- Staff on wards wore red tabards indicating they were undertaking medicines rounds and should not be interrupted. We saw that staff took their time to check the prescription chart when preparing medicines and prior to administration to make sure the patient was correctly identified. Staff supported the patient to take their medicines where this was required.
- We noted in the minutes of the Medicines Safety Group held on 3 August 2015 a total of 17 incidents which occurred in surgical areas had been discussed and reviewed.
- Where patients were noted in our review of their records to have required antibiotics, these had been prescribed in accordance with local antibiotic formularies. We noted in the Medicines Safety Group meeting minutes for 3 August 2015, action had been taken where a patient with penicillin allergy had been prescribed inappropriate antibiotics to take home.
- Our review of patient records demonstrated that allergies had been clearly documented in patient prescriptions. Prescription records were clear and evidenced the different routes, times and frequency of medicines to be given, as well as those that were prescribed on an as required basis.
- We observed nursing practice around the protocols for administration of controlled drugs (CD) as per the Nursing and Midwifery Council – Standards for Medicine Management. Staff followed procedures correctly and ensured that all necessary safety checks had been carried out prior to the patient being administered the CD.
- Our checks on the wards and theatre CD registers demonstrated safe record keeping with regard to all aspects of CD management. We noted from information reviewed, the medicines department had undertaken regular audit of the management of controlled drugs. We reviewed the results of the April – June 2015 audit in various wards including Dowland, Eliot, Evelyn, Gray and theatres. Results ranged from the lowest score of 75%, which related to crossing out errors, up to 100% in a number of the measures. Action taken had been communicated to wards and we reviewed information which confirmed this with respect to Edison Ward.
- We checked the arrangements for storage and management of substances, which came under the control of substances hazardous to health (COSHH) on two wards. We found the assessments on Gray Ward had last been updated in April 2013 and there were no dates on the assessment checks for Edison Ward.

Records

- We found from our review of patient treatment and care records that a standard approach was used for these, although there was a slight variation in day surgical documents when compared with inpatient records. Care plans were not individualised but were generic, covering a range of nursing assessments related to activities such as nutrition, washing and dressing, sexuality and body image, sleeping, mobilising and disabilities.
- Risk assessments were part of the record and included pressure areas, nutritional, patient handling, falls and bed rails assessments. Information recorded assisted nursing and other staff to understand what was expected of them in terms of supporting the delivery of care; however, there was no additional information to indicate patient's specifics wishes, preferences and choices.

- Essential information to keep people safe had been identified and acted upon, for example, the use of bed rails or specialised mattresses. Information with this regard was communicated to staff in the care records and reinforced at handover between shift changes.
- Where people had attended pre-operative assessment, the information gathered at this appointment had been recorded on the nursing record and was made available for the subsequent admission.It was reported by the pre-assessment nurse that patient notes were not always available, but this was mainly related to the recent move of gynaecology patients and notes not being on-site.The notes clerk would endeavour to have notes ready, but if they could not locate them, they would prepare a temporary set. Notes had been found on occasion to be muddled, with misfiled information, which were reported on the Datix system. No major issues had occurred as a result of this and staff had, where necessary, contacted patients directly if a problem arose as a result. For example, mislabelling of a blood sample. We noted issues related to availability of patient records had been included on the risk register.
- Most patient records we reviewed had been completed to a standard which enabled staff to understand the patients needs, treatment and care. Care records and notes werestored appropriately and managed safely during ward rounds.

Safeguarding

- A formal safeguarding policy was provided to staff which outlined the underpinning principles, responsibilities and the governance and reporting structures. This was found to be accessible on the hospital intranet.
- We noted from minutes of the adult safeguarding meetings that there was multidisciplinary representation. Discussion covered a range of relevant matters, such as domestic violence, training, dementia, mental capacity and deprivation of liberty safeguards.
- Staff demonstrated a suitable level of knowledge and understanding around safeguarding vulnerable people. They were aware of the consultant and nurse lead for safeguarding, as well as escalation procedures.
- We were unable to identify specific training rates for safeguarding adults by ward area. The exception to this was in the Theatre Admissions Unit, where we foundsafeguarding vulnerable adults traininghad been completed by 82% of staff. We noted however from the surgical directorate training figures provided to us for October 2015, safeguarding adults level one had been completed by 80.84% of staff, level two by 75.45%.

Mandatory training

- Nursing staff confirmed there was an expectation to undertake mandatory training and that staff had to take responsibility for completing this. Subjects included for example; Infection prevention and control, health and safety, manual handling and resuscitation.
- Mandatory training rates were monitored as part of key performance indicators. We found for example, acompliance rate of 92% on Gray Ward and 100% in the Theatre Admissions Unit. On Edison Ward 90% of staff had completed the required training and on Dowland Ward the figure was 83%.However, on Evelyn Ward mandatory training was much lower at 66% year to date. This was said to be related to the high level of activity on the ward and not being able to free up time.

Assessing and responding to patient risk

- Staff had completed comprehensive risk assessments with respect to patient falls, nutritional needs and venous thromboembolisms (VTE). In addition, patient assessment included identification of potential risks associated with having a general anaesthesia. Patient records we reviewed confirmed these measures had been undertaken.
- Within the patient records we reviewed, we were able to see evidence that staff were complying with the National Institute for Health and Care Excellence (NICE) quality standard related to VTE risk assessments and management. We found that all patients, on admission, had received an assessment of VTE and bleeding risk. Where interventions were required, these had been acted upon, including the use of prophylaxis medication and support stockings. Compliance with VTE checks had been monitored and we saw a 95% compliance rate year to date on Evelyn and Gray Wards and 100% on Fletcher Ward.Compliance was lower on Edison Ward, at 71%.
- Pre-operative assessments included a comprehensive review of the patients previous and current health problems and needs. Physical assessments had been carried out in line with guidance on pre-operative assessment for both day case and inpatients.

Surgery

- We attended the trauma meeting, which was consultant led and included discussion of patient treatment and care prioritised based on safety parameters.
- We noted patient risks were managed positively through the appropriate use of interventions. This included, for example, ensuring high risk patients who needed surgery were not admitted as a day case. Where required, patients were seen by the tissue viability nurse in order to ensure potential risks to their skin were managed effectively.
- The American Society of Anaesthesiologists (ASA) fitness assessments for anaesthetics were completed on all patients prior to surgery and those classified as an emergency were identified accordingly.
- Staff followed a patient observation and escalation policy, which was noted to reflect the guidelines from the National Institute of Clinical Excellence (NICE) CG 50, the National Patient Safety Agency (NPSA) (2007), the Department of Health; Competencies for Recognising and Responding to Acutely ill Patients in Hospital (2009) and the Royal College of Physicians; Standardising the Assessment of Acute Illness Severity in the NHS (2012). We noted staff had completed the required national early warning score observational tool, known as NEWS. Resulting scores from this enabled staff to alert medical staff where a patient's condition was deteriorating. We saw evidence in patient notes of the responsiveness of medical staff in such a situation and the actions taken to manage associated risks to the patient's wellbeing.
- Compliance with the completion of the NEWS was monitored and we saw for example on Edison Ward a 98% compliance rate, 99% on Gray Ward year to date and 100% on Fletcher and Evelyn Wards.
- In conjunction with the NEWS staff completed a specific reporting tool, known as 'SBAR'. This recorded details about the situation, background details about the patient, their assessment, such as blood pressure and respiratory rate. The final section related to recommendations, for example, the need for immediate attention.
- Nursing staff reported the Critical Outreach Team as being responsive when their advice or interventions were required.
- Staff followed a sepsis pathway for the management of patients whose condition met the criteria.
- We noted from patient records and observed staff undertook two hourly comfort rounds, which provided an opportunity for nursing staff to check the status of the patient and to update risk assessments accordingly.
- We observed the completion of safety check list in one theatre on the first day of our visit to theatres. Correct safety checks were seen to be carried out before commencement of surgery. However, the scrub nurse did not undertake the final checks of swab counts and instruments before the surgeon had de-scrubbed. There was no verbal confirmation of the final checks and completeness.
- Northwick Park Hospital used an adapted and updated Safer Surgery Checklist, which was recorded on the electronic Theatre Information System. We found team briefings were carried out , but not included in any audit. They were notrecorded on theatre information system. Debriefs were not fully embedded in the procedure. Theatre staff acknowledged that engagement in this area needed to be improved.
- Quarterly audits of staff compliance with the World Health Organization (WHO) safety checks had been carried out for the periods covering July 2014 to March 2015, the results of which we were provided with. We saw, for example, compliance with sign in at 99.6%, time out at 98.7% and sign out recorded in 97.3% of cases for the quarter four period. The audit provided data analysis and discussion, with comparisons across the respective quarters. We also saw that the audit had been presented at the Critical Care and Anaesthetics Clinical Governance meetings in March and the Theatre Users Committee in April 2015. There was an expectation that improved results would be achieved in quarter four 2015/16, following discussion with consultants of the need to sign out before leaving theatres.
- We witnessed evidence indicative of the team brief having not been appropriately carried out pre-operatively. The positioning of a patient after they had been anaesthetised presented some initial difficulties, as there were differences of opinion as to how the patient should be positioned for their surgery. This was not resolved until the surgeon corrected the positioning. Had this been discussed and agreed in the team brief, staff would have been aware prior to commencement of the required positioning.
- Consultants and other levels of medical staff reported the lack of consultant radiology cover at weekends led

to scans being reported by specialist registrars (SpR's) and amended by consultants on Mondays. They reported an apparent 25% amendment rate, with missed pathologies and provided examples to us. The lack of consultant radiologists presented a potential risk to patient safety with regard to diagnostic skills.
- Surgical outliers were identified on electronic patient boards on wards and information was communicated to medical staff at shift changes.

Nursing staffing

- Staffing problems, such as sickness absence or demands on staff as a result of patient acuity, were noted to be discussed at the bed status and safety huddle we attended on the morning of 21 October 2015. Staffing levels were also monitored as part of the workforce safer staffing performance indicator. For example, we noted year to date a vacancy rate of 6.2% on Gray Ward and sickness at 1%. On Evelyn Ward they had a vacancy rate of 33.6% as of September 2015 and a sickness rate of 9.7%. There were no vacancies on Dowland Ward.
- Rotas provided to us for Edison and Evelyn Wards indicated the arrangements for staff cover, with balance of skill mix across day and night shifts. We noted in ward monthly staffing reports information was collected with regard to use of permanent, bank and agency staff. For example on Evelyn Ward they had used bank nurses on 53 occasions during July and 88 in August 2015 and 60 agency nurses in July and 64 in August 2015.
- Information was collected on average vacancy fill rates for registered nurses. In August 2015, the average registered nursing vacancy fill rates on surgical wards ranged from 77% on Elliot Ward, 82% on Dowland, 86% on Fletcher and 91% on Edison Ward. September 2015 figures indicated fill rates of 81% on Dowland, 90% on Elliot, 92% on Edison and 115% on Gray Ward.
- Nurse to patient ratio varied on wards. For example on Evelyn Ward the ratio was between one registered nurse to six patients and no more than one registered nurse to 6.7 patients on days and at night it ranged betweenone nurse to 11.6 patients and one to 16.6. For this reason, the ratios on nights were categorised as red on the workforce and safety dashboard. On Gray Ward the ratios fell in the green category for days and nights.
- We observed on our visits to the wards the expected and actual staffing levels displayed for day and night shifts. On the day of ourvisitsurgical ward staffing levels matched expectations.
- We were told there were four staff in the Theatre Assessment Unit (TAU) working Monday to Saturday who looked after all ambulatory surgical day patients. However, the service was challenged as there were frequently 10 patients who needed to stay in overnight due to lack of ward beds. As a result, additional nurses had been recently recruited to enable overnight care.
- In the absence of the theatre manager, we spoke with a band six staff member in theatres about staffing and they were not aware of the establishment but believed that it followed the Association for Perioperative Practice (AfPP) guidance. This was confirmed later with the Head of theatres who verified that theatre staffing establishments was based on benchmarking information and guidance from the AfPP, which advises three qualified staff and one unqualified staff per theatre. Shifts started at 8am, and we were told there tended to be four scrub staff and one anaesthetic practitioner. A band seven theatre nurse told us they were unable to undertake managerial duties as they had to be hands on in the theatre due to a lack of scrub staff. They added that the staffing levels did not affect patient safety but did impact on efficiency. Subsequent discussion with the general theatre manager confirmed the staffing arrangements, which included having three qualified and two healthcare assistants at night for the emergency NCEPOD theatre.
- We were provided with information to demonstrate agency and bank staff had local induction and orientation to the wards and theatre departments. This included staffbeing made aware of protocols, access to emergency equipment and other safety related information.
- We attended the morning handover between night and day staff on Evelyn Ward. This was a two part process, with basic information about each patient handed over in the office and any investigations or specific care needs communicated. Staff were also made aware of patients who were going home or were receiving terminal care. Nurses for each section of the ward then received a more detailed handover of their patients,

with staff referring to observational charts and medication records. This part of the handover did not take place at the patient bedside, therefore patients were not involved.

Surgical staffing

- Consultant surgeons and anaesthetists made up 35% of the medical staffing. Middle grade doctors, those with at least three years as a senior house officer (SHO) or a higher grade made up 11% of the workforce. Registrars contributed 44% to the workforce and junior doctors, those in their foundation years one or two were at 10%.
- We reviewed medical staff rotas provided and observed there was appropriate consultant cover.
- Maxillo-facial and ENT medical staff shift patterns supplied to us indicated the following: 24/7 consultant on-call cover, 24/7 registrar on-call cover, Weekday 7am to 7pm two SHO cover on site and weekday 7pm to 7.30am a clinical fellow provided on-call cover on site.
- The arrangements for ENT consultant on call cover was 24/7 and 24/7 registrar on call cover also with 24/7 SHO cover Monday – Sunday on site.
- General surgery cover was described in information provided as follows: Consultant on-call cover 24/7 with a consultant on-site to 9pm every day. An admitting consultant was on-site from the hours of 8am to 5pm; a late consultant 12pm – 9pm. Day consultants were supported by SpR 8am – 8pm; SpR CEPOD 8am – 5pm; the first SHO covered the Surgical Assessment Unit; a second SHO covered CEPOD 8am – 5pm. Ward cover included one consultant with an SpR/staff grade and two SHOs with at least one first year (FY) doctor and at least one Specialist Nurse Practitioner.
- There were twice daily ward rounds Monday to Sunday in Maxillo-facial and daily ward rounds Monday to Friday for ENT patients.
- Locums were used where necessary but were said by consultants and other medical staff as not always able to make suitable clinical judgements. Furthermore, we were told they were not always supplied with passwords and did not complete an induction process so were not sure of how the systems ran.

Major incident awareness and training

- There was a protocol for deferring elective activity to prioritise unscheduled emergency procedures in theatres.
- A major incident protocol was available to staff to access and we noted actions to be taken were clearly defined. We noted action cards were available to staff in theatres.
- Two members of theatre staff who spoke with us did not know about the procedures to follow if there was a major incident, although one was aware of the information folder for such an event. Staff commented on the reliance on senior staff to advise as to what should be done.

Are surgery services effective?

Good

We rated effectiveness for surgery as good.

National guidance was used to support the delivery of treatment and care.

Staff caring for patients had undertaken training relevant to their roles and completed competence assessments to ensure safe and effective patient outcomes. Staff received an annual performance review and had opportunities to discuss and identify learning and development needs through this and supervision meetings.

Patient surgical outcomes had been monitored and reviewed through formal national and local audit. Most outcomes were within or above the average comparator. However, there were areas which performed less well including the National Bowel Cancer Audit for 2014, the patient hip fracture audit for 2014, and the National Emergency Laparotomy Audit for 2014 and 2015.

Policies and procedures were accessible to staff, including agency staff via the trust computer system.

We observed risks assessments in place for patient's nutritional needs and these had been reviewed as part of their progress reports.

However, the Mental Capacity Act (2005) and Deprivation of Liberty Safeguards were not understood by all staff and no training for these subjects were identified as being available.

Evidence-based care and treatment

- Our observational checks of patient records confirmed compliance with NICE QS66 Statement 2: Adults

receiving intravenous (IV) fluid therapy in hospital are cared for by healthcare professionals competent in assessing patients' fluid and electrolyte needs, prescribing and administering IV fluids, and monitoring patient experience. We saw that intravenous fluids and medicines had been prescribed by a doctor. Records of administration had been completed and recorded on prescription charts and fluid balance forms.

- Patients who were assessed to be at risk of VTE had been prescribed and administered with VTE prophylaxis in accordance with NICE guidance.
- Nursing and medical staff assessed the needs of the patients on admission and throughout their hospitalisation. Treatment and care was planned and delivered in line with evidence-based, guidance, standards and best practice. Monitoring of patient safety outcomes enabled the surgical directorate to assess such standards were being delivered.
- Policies and procedures were accessible to staff, including agency staffvia the trust computer system.
- Technological equipment was used to monitor patient well-being, toenhance the delivery of effective care and treatment in theatres, recovery and on wards.
- Surgical services were managed in accordance with the principles outlined in National Confidential Enquiry into Patient Outcome and Death (NCEPOD) classifications around access to emergency theatres and the Royal College of Surgeons (RCS) standards for unscheduled surgical care. For example, theatre five was used for emergency surgical patients and patients were booked via the completion of a proforma and assessed and prioritised by an anaesthetist. The classification was done at the time of the decision to operate and when the theatre was booked. The correct classification was supplied to the theatre co-ordinator when the patient was booked so an appropriate priority was assigned to the case. The classification was recorded in the patient's case notes.
- We found there was an Enhanced Recovery Programme, led by the orthogeriatrician and supported by a trauma nurse co-ordinator, which ensured the appropriate pathway was followed by patients who received treatment and care followinga fractured neck of femur.A discharge co-ordinator was responsible for liaising with occupational and physiotherapists with respect to planning for discharge home or to on-going care.
- Professional guidance was followed with respect to recording and management of medical device implants. Data was submitted to the national joint register, subject to patient agreement.
- Preoperative tests were undertaken in accordance with best practice guidance. The assessment included a review of patient's physical well-being and staff provided advice with respect to optimal fitness for surgery. This included advice related to diet, medicines, mobility and instructions regarding preparation for surgery.
- Steps were taken within the operating theatre to minimise the risk of patients developing a surgical site infection. We saw attention was given to the correct procedures of preparing the patients incision site and post-operative wound dressings. We requested information on surgical site infections for the location but did not receive this.
- The post-operative recovery of patients focused on supporting them to be as mobile as possible and to regain independence. The resumption of normal eating and drinking was encouraged where appropriate and, unless a clinical indication, drips and urinary catheters were avoided.
- We noted there was a programme of audit for the period 2015/16, which set out the areas of focus by location. The majority of evidence gathering were not expected to be completed until March 2016.

Pain relief

- We found from our observation of patient records, which included the completion of comfort rounds and observational tools, patients had their pain assessed. A scoring system was used to rate the level of pain.
- Staff reported having access to the pain team when required, this included anaesthetist advice. We found there was consideration of the different methods of managing patient's pain, including patient controlled analgesia pumps.
- We observed and heard staff asking patients if they had any pain. We also saw them act on this where patients indicated they had pain. Pain relief, including controlled drugs were only administered after nursing staff checked patient details against their prescription.
- The pre-assessment process enabled staff to identify patients who needed to be seen by the anaesthetist for a review of their pain.

Surgery

Nutrition and hydration

- We observed risks assessments in place for patient's nutritional needs and these had been reviewed as part of their progress reports.
- A trust wide protocol was in place forfasting patients prior to surgical procedures. In addition to this, we saw there was fasting instructions within the letter sent to patient regarding their admission.
- Where patients required intravenous fluids, these had been prescribed by the doctor. We saw that fluid balance charts were provided and used to monitor the patient input and output. However, these had not always been completed with respect to daily totals.
- Catering staff were observed checking with staff who could eat and drink on Evelyn Ward.
- Anti-nausea medicines had been prescribed for patients who experienced nausea and vomiting after surgery.
- There was access to dietitian services pre and post operatively, along with support from the speech and language therapy (SALT) team for patients who had difficulties in swallowing. Although dietitian's were not available on-site at weekends, there was guidance related to nutritional feeds on the intranet.

Patient outcomes

- Patient outcome data was available for a number of surgical specialties. These results presented a mixture of positive and negative patient outcome information as follows:
- The service was regularly reviewing the effectiveness of care and treatment through local and national audit. We saw within the audit programme for 2015/16 that results from many of thesurgical related audits including: National Complicated Diverticulitis Audit (CAD), National Vascular Registry, Potential Donor National Audit, National Inflammatory Bowel Disease, the assessment of periodontal health pre- and during orthodontic treatment and the National Ophthalmology Audit were expected in March 2016.
- Patient Reported Outcome Measures (PROMS)were responses from a number of patients who were asked whether things had 'improved', 'worsened' or 'stayed the same' in respect to four surgical procedures, (groin hernia, hip replacement, knee replacement and varicose veins). The majority of indicators for NPH respondents suggested an improving picture when compared to the England average.
- The rate of laparoscopic surgeryattemptedwas 83.3%,against an England average of 54.8%. Laparoscopic surgery is recognised as an approach which generally leads to less risk of complications and a speedier recovery.The higher hospital figure indicated a positive approach to achieving better patient outcomes.
- The National Lung Cancer Audit for 2014 indicated that the trust performed better than the England average intwo areas. Thesewere: 96.8 % of patient's treatment and care beingdiscussed at amulti-disciplinary meeting and 95.8% of patients receiving a CT scan before having a bronchoscopy.The CT scan helps determine diagnosis and is recommended by the National Institute for Health and Care Excellence (NICE).
- However, the National Bowel Cancer Audit for 2014 indicated that data completeness for patients having major surgery was poor at 30%, compared with an England average of 87%. Of the 144 cases of major surgery, only 30% had complete data on the seven main indicators in the audit, which was significantly below the required standard of 80%.This low level of data completion did not give an accurate indication of patient outcomes.
- Northwick Park Hospital did not participate in the National Prostate Cancer Audit or the National Oesophago-Gastric Cancer Audit 2014.
- Northwick Park Hospital (NPH) did not participate in the Anaesthesia Clinical Services Accreditation scheme (ACSA).
- The hospital submitted data related to five hip replacement procedures to the National Joint Registry (NJR) so far in 2015. The data submission was worse than expected for four areas, including consent at 57.8% compared to national average of 85%. The time for submission of data was 81 days in comparison to the expected target of 30 days. There was no outcome data for the hip replacements undertaken between 1 April 2014 and 31 March 2015.
- The Hip Fracture Audit for 2014 indicated that NPH performed better in three measures when compared to the England average. Pre-operative assessment by a geriatrician was achieved in 98.6% of patients, compared with England average of 51.6%. Bone health medication assessment was completed in 99.2% of patients, compared to 97.3% England average. Falls assessment achieved a 99.2% rate, against a 96.8% England average.Three areas where the location performed less than the England average related to

patients being admitted to orthopaedic care within four hours, surgery being undertaken on the day of admission or the day after and patients developing pressure ulcers.

- Information related to patient hip fractures was submitted to the National Hip Fracture Database annual report 2015, (NHFD). This presented mixed results.We reviewed the annual report and noted 47.4 % of patients were reported to have been admitted to an orthopaedic ward within four hours. The London average was 29% and overall average 46.1%. The percentage of patients mobilised the day after surgery was 50%, compared with a London average of 69.4% and overall average of 73.3%. The location performed better (above 90%) with regard to mental test assessments, preoperative medical assessment, a falls assessment and bone health assessment.
- Northwick Park Hospital was part of the North West London Trauma Network and had a shared aim of improving patient care and their outcomes.
- The trust's self-reported National Emergency Laparotomy Audit data for 2014 indicated the provision of facilities required to perform emergency laparotomy was unavailable in 10 of the 28 measures. This included for example; no details about the availability of a reserved operating theatre for emergencypatients 24/7, lack of information to confirm a minimum four tier emergency general surgery (EGS)rota at all time, details about the availability of a critical care outreach team 24/7 and if there was a policy for anaesthetic seniority according to risk. There was no information about the pathways for enhanced recovery of patients and no details to indicate the responsibilities of the surgeon to formally hand over patients in person.
- The National Emergency Laparotomy for 2015 indicated four areas of concern. This included; the reporting of CT before surgery, pre-operative review by surgeon and anaesthetist, presence of surgeon and anaesthetist in the operating theatre and an assessment by an orthogeriatrician in patients above the age of 70 years.
- Standardised relative risk readmission rates for the location were reviewed with caution, taking into account the possibility of inaccuracy since the merger. However, we noted from information of the top three elective surgical specialties of urology, colorectal and general surgery, all had worse than the national average risks of readmission, ranging from 18%, 64% and 34% respectively.

Competent staff

- Learning and development needs were identified in staff performance review meetings. In addition, there was an expectation in some surgical specialties that nursing staff would have certain skills and expertise.Nurses on Gray Wardwere expected to complete ear nose and throat (ENT) training, after which supervision and completion of competency assessments were required. Also Staff, including senior healthcare assistants on Gray Ward, undertook tracheal suctioning training and we saw their completed competency assessment books to confirm this.
- Pre-assessment nurses had completed the pre-assessment training, which included an internal course, with examination and completion of competencies. Two staff places were funded for pre-assessment nurses to attend the 'developments in pre-assessment', which were held externally.
- Staff reported a proactive approach to training and of having access to the electronic training system. Band six nurses met together with their ward manager on Gray Ward to discuss learning and any learning actions and there was shared learning with band five nurses after this.
- A Physiotherapist told us they had good training, that it was one of the best hospitals for physiotherapy training opportunities; compared to others they had worked in.
- Staff told us they had been encouraged and given opportunities to develop. For example, on Edison Ward there were nurse practitioners, who had received advanced training in specialties and were able to prescribe. Their role was expanded to take over the role of junior doctors. We observed a practitioner taking time to ensure a procedure was completed for one particular patient.
- Nursing and physiotherapy staff confirmed they had their performance reviewed through a formal appraisal. We noted performance figures with respect to appraisals and saw on Gray Ward year to date a figure of 76%. On Evelyn Ward the rate was 46%.
- A junior doctor told us they were not allocated time for learning and could not take study leave. As a result, they had not found time to complete the required learning. We reviewed the ENT training rota and identified opportunities for learning built in to the working timetable.

- Information provided to us indicated there were 112 surgical staff in the surgical directorate, although these numbers were not site specific. Of these, we noted there had been 11 staff who required revalidation up to this point in time and these had been completed.

Multidisciplinary working

- Nursing staff, physiotherapists and dietician's reported good multidisciplinary working. In most cases, all necessary staff, including those in different teams and services, were involved in assessing, planning and delivering people's care and treatment. From patient records reviewed, we sawthe extent of involvement of the various services, with entries made of their interventions and patient progress. This included arrangements around discharge.
- A member of the physiotherapy staff commented on the high activity of Evelyn Ward but that it was a good place to work, with good multidisciplinary team work. An example of the effectiveness of the physiotherapy team was described to us. A daily morning meeting took place, in which a member of staff from each ward presented prioritise and expected workload so that areas could be appropriately supported.
- We observed good multidisciplinary working on wards. Registrars knew all their patients and worked in a flexible way with other members of the team. Multidisciplinary team (MDT) sessions were used to improve the discharge process and bed availability.
- We observed there to be effective team working between theatre and ward staff around the flow of patients and sharing of information.
- Physiotherapy and occupational therapy staff attended wards and were aware of the patients who they were treating or reviewing.
- Discharge arrangements were considered as part of the pre-admission assessment or as soon as possible after admission where a patient came in as an emergency. Any equipment needs were communicated to occupational and physiotherapy staff. Where community nursing was required, a referral process was activated.

Seven-day services

- There were arrangements between consultants, anaesthetists, SpR's, clinical fellows and SHOs to cover the surgical specialties out of hours.
- Pharmacy arrangements out of hours included an on-call pharmacy service available for emergency supplies and queries. On weekends and bank holidays, a pharmacistundertook checks ofthe pharmacy diary for any written requests.
- Consultants and other medical staff told us there was a lack of consultant radiology cover at weekends, which impacted on the ability to have patient scans accurately reported on.
- There was a seven day physiotherapy service in place across all specialties within the hospital. Emergency out of hour's on-call service for patients with respiratory complications available out of hours 365 days of the year operating from 16.30 to 8.30 am.
- There was a seven day occupational therapy service in place across all specialties within the hospital.

Access to information

- We observed information needed to deliver effective care and treatment was available to ward and theatre staff. This included details of patient admissions, theatre schedules, patient records, risk assessments and guidance.Nursing staff working in pre-assessment told us there were occasions where patient notes were not always available, resulting in a temporary set having to be made up until the original notes arrived. Such problems were discussed at department meetings and reported via Datix.
- Information to support the delivery of services was accessible on the trust intranet and also in paper copies in most areas.
- We noted in minutes of clinical governance meetings that theatre safety bulletins were discussed, along with patient safety alerts.
- Referral information for community services, discharge, transfer and transition was shared appropriately and in a timely way.
- An electronic discharge summary was completed for each patient. Patient discharge information was communicated to GPs, with details of the surgery or treatment the patient had received. Care summaries were provided on discharge to ensure continuity of care within the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff working at the hospital had access to information related to the Mental Capacity Act 2005 and consent, as

well as Deprivation of Liberty Safeguards (DoLS). Assessments for potential deprivation of liberty was expected to take place on admission alongside capacity, and considered at times where there were changes to a patient's care and treatment plan and at discharge, following the process and decision. In our discussion with staff, we found there was a lack of understanding and awareness from theatre staff about the MCA and DoLS. We noted there was no training at the time identified on the electronic training system.

- We listened to a doctor going through the consent process with a patient. They discussed the procedure, the risks related to infection, deep vein thrombosis or pulmonary embolism and how these were managed. They also covered the potential to change from a key whole approach to a traditional procedure and the implications this would have on their length of stay. The doctor also took consent for blood transfusion, after explaining the likelihood of this not being required.
- A patient on Edison ward explained how medical staff had explained their surgical procedure prior to their consent. Another patient told us the information they were given prior to giving their consent included the risks and benefits. Consent was also obtained prior to performing tests and when delivering care. For example, a patient told us the staff always asked their permission before taking blood.
- We heard the theatre escort staff seeking permission before undertaking the necessary safety checks prior to leaving the Theatre Admissions Unit.
- We noted in our review of patient records, consent forms had not always been completed with the full level of detail of the doctor who was signing the form. For example, one form only had the doctor's surname and another indicated the grade of doctor but was not specific.
- An audit of compliance with expected standards around consent was undertaken in July 2015. The number of consent forms included in the audit at NPH was 93 and of these 45.2% had been signed by the surgeon undertaking the operation.30.1% had not been signed by the operating person, 16.1% were illegible and 8.6% of notes were not available.The main grade of doctor obtaining consent was an SpR, at 37.6%, followed by the consultant (25.8%). Statements from the health professional were completed in all cases. The benefits of having surgery were recorded on 94.6%, risks on 97.7% and a signature of the patient or parent was 98.8%.The remaining consent had an x but no explanation as to the reason.
- An action plan had been developed from the audit and included theformal consent training, along with focus on consent at induction for registrars and senior house officers.The latter of which had been achieved.
- We reviewed minutes of the theatre user committee meeting, held on 15 June 2015. Information therein included discussion around consent of patient for photographs taken during surgical procedures. It had been noted that there was no standardised approach across the trustand there was a need to formalise processes, with suggestions discussed. This included members meeting again to draft a policy. We noted further discussion around this matter at the meeting which took place on 28 July 2015. Action included obtaining sign off of the policy.

Are surgery services caring?

Good

Patients reported positively with regard to the quality and standards of care they received from doctors, nurses and the multidisciplinary team. Staff respected the individuality and needs of patients and treated them with kindness, courteously and with respect. Patients told us their privacy and dignity was respected and they and those who they wished to be were involved in decisions about their treatment and care.

Patients reported their relatives and those closest to them were kept informed as much as they wished them to be.

There was access to information and support from relevant expertise where patients required additional emotional and psychological care.

Compassionate care

- Patients we spoke with reported positive experiences with regard to their treatment and care in surgical areas. Individual staff members were singled out for praise by two patients. Staff were described by one patient as "all good, I can't complain." Another patient said staff were very friendly, kind and caring, adding "I think it is great."

A patient on Edison Ward told us they had been a previous patient and they had been, "very well cared for." Nurses on Dowland Ward were described as "brilliant, kind and caring" by a patient.

- A patient who had come in via the emergency department told us their care at the emergency department had been "wonderful, very, very good" and said they would have given them "top marks." Since their arrival on the Dowland Ward they had experienced "lovely staff", who were "amazing" and responded very quickly.
- Patients on Gray Ward praised the staff and, in particular, one patient who had their surgery at a different hospital, spoke about the experience at Northwick Park as being much better. The doctor was said to have visited this patient every morning, providing reassurance. Another patient had experienced the hospital services on more than one occasion and told us the care on Gray Ward was, "excellent", the nursing staff were described as conscientious and the doctors came every day, which helped in making them feel relaxed and calm.
- We were told by patients on Evelyn Ward nurses were very good, very caring and responsive.
- Five patients spoke with us on the Theatre Admissions Unit and the majority gave us positive comments including, "everything is marvellous" and "great, very caring." Other feedback included one patient feeling distressed by the behaviour of a doctor who didn't show them their scan or allow them to ask questions.
- We made observation of staff interactions with patients and reviewed information within patient records. We found nursing and medical staff understood and respected people's personal, cultural, social and religious needs. Relevant information was taken into account in addressing personal needs, such as diet and interpretation needs on wards. Patients were encouraged to regain their independence as soon as possible after surgery. This included mobilisation, eating and drinking and attending to their own personal care needs. We noted too that when assistance was required, staff provided support in a timely manner and were kind and attentive.
- Staff were observed to take their time to interact with patients in a respectful, friendly and considerate manner. Patients reported they were looked after in a respectful and dignified manner.
- We observed staff being encouraging, sensitive and supportive towards patients and their relatives. For example, we observed a porter providing help to a patient in a kind manner when preparing them to go for an investigation.
- We observed staff making sure that people's privacy and dignity was always respected, including when care was being provided and during ward rounds. Privacy curtains were used and nursing staff ensured patients were not exposed when mobilising or moving between departments.
- We observed nursing and medical staff paid due regard to patient confidentiality, both in the discussion of information, sharing relevant patient details at shift changes and in the handling of patient records.
- When we followed the patient journey from the Theatre Admissions Unit, we noted the anaesthetist introduced themselves and explained all procedures and the process that would be happening.
- Friends and Family test results for the period March 2014 to February 2015 indicated an average response rate from surgical wards and the Theatre Admissions Unit ranging between 18% and 74%. The lowest rate of recommendation was reported at 67% on Edison Ward in March 2015. However, we noted recommendations were reported by 100% of respondents on at least one occasion on each surgical area during the period, with the exception ofEdison Ward. One patient who spoke with us on Edison Ward told us, "I would not change anything" and added that they would recommend the hospital.

Understanding and involvement of patients and those close to them

- Patients who spoke with us reported they had been given information by staff in a way which helped them to understand their care and treatment. A patient told us, they had been kept informed and everything had been explained well," in a way I could understand." They told us their husband had been kept informed and all staff were helpful. Another patient reported their treatment and care had been fully discussed and they had been involved in making decisions accordingly. They also told us their relative had been able to raise questions and had these responded to.
- A patient commented on the doctor's rounds, which they said sometimes, left them confused. For example,

they said something was explained on one day about their surgical procedure but the next day information was different and the proposed option was not discussed again.

- A patient on Dowland Ward commented to us favourably on the pre-assessment service and level of information provided. The information was covered again after their admission and they had full explanations at each stage of their treatment and care. For example, they told us the staff in anaesthetics were good and they explained everything.
- Staff recognised when patients needed additional support through the use of expertise and skills of specialist nurses and allied health professionals. They were able to access language interpreters and had other resources available to assist in effective communication.
- The generic care planning documentation used allowed staff to enter information about the patients profile and to assess their needs. However, we did not see any supportive evidence to indicate detailed discussion of their health beliefs, concerns and preferences and how this informed their individualised care.
- Information in consent forms and discussion with patients indicated they had been supported by staff to understand relevant treatment options, including benefits, risks and potential consequences.

Emotional support

- The patient assessment and on-going progress notes indicated physical and psychological needs had been regularly assessed and addressed by staff. This included needs related to nutrition, hydration, pain relief, personal hygiene and anxiety.
- Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. Regular checks of patient wellbeing were taken in the form of comfort rounds. Family and carers were encouraged to visit and be involved where possible in supporting their relative. Carers who spoke with us reported they had been involved in discussions.
- There was access to expertise and additional advice and support from specialist nurses, learning disability and dementia lead nurses.
- Patients were encouraged and supported by staff to manage their own health, care and wellbeing and to be as independent as possible. Where patients were self-caring, this was recorded in nursing records and communicated to staff accordingly.
- There was access to chaplaincy and the patient's advice and liaison team.

Are surgery services responsive?

Requires improvement

There were no formaladmission pathways for some patient conditions. Criterion for admission to the surgical assessment unit was not always adhered to.

Adjusted referral to treatment within 18 weeks was worse than the England average between the period of September 2014 and April 2015 for five surgical specialties. The referral to treatment for incomplete pathways in October 2015 was 93.2% which was above the 92% standard.

Theatres were not always effectively utilised and operating sessions started and finished later than planned, which impacted on patient discharges. Whilst the hospital operational management team had oversight of the status of the hospital at any given time, lack of bed availability impacted on the flow through recovery and the theatre admissions unit to surgical ward beds post operatively.

The percentage of patients with a fractured neck of femur seen and operated on within 48 hours was worse than the England average. Length of stay for patients who had elective surgery at Northwick Park Hospital was better than the England average for all types of surgery. For non-elective surgery the length of stay was worse for patients who had trauma and orthopaedic and vascular surgery, compared to the England average.

The individual care needs of patients were fully considered and acted on by the multidisciplinary team. Arrangements to support people were available.However, where people had cognitive impairment, such as dementia, appropriate measures were notprovided. There had been little focus on developing the surgical services to improve the

environment for such patients receiving surgery. Translation services were available and staff had access to information and expertise to facilitate responsive communications.

The complaints process was understood by staff and patients had access to information to support them in raising concerns. Where complaints were raised, these were investigated and responded to and where improvements were identified, these were communicated to staff.

Service planning and delivery to meet the needs of local people

- Patients who discussed their experiences indicated to us their needs and personal preferences had been taken into account when accessing the service and with respect to their subsequent treatment and care.
- There were suitable arrangements to ensure people's needs could be addressed regardless of complexity.
- There was access to outpatient consultation and pre-admission assessment. The latter was viewed as a positive aspect of the service by those who had attended it.

Access and flow

- Patients were referred to the hospital outpatient department via their GP, before the consultant confirmed the need for surgery. Access to surgical services also took the emergency department route, subject to assessment, investigation and clinical decision processes.
- There was a patient access policy for 18 week referral to treatment (RTT). The clinical management of each patient on the waiting lists was the responsibility of the clinician in charge of the patient's care ensuring they were put on the right pathway, whether routine or urgent as well as by sub specialty.
- Five surgical specialties were not meeting the required RTT standard of 90% and were also below the England average of above 85%. These were general surgery (69.1%); oral surgery (74%); ENT (82.8%); urology (83.2%); and trauma and orthopaedics (83.4%).
- A performance scorecard for the surgical division indicated a year to date figure as of July 2015 related to 31 day first treatment, based from the decision to treat.This was achieving 92.90%. The 31 day second or subsequent decision to treat for surgery was achieving 97.93%.
- A bed status and safety huddle meeting took place each morning and again at lunch time. We attended one of thesewhich waslinjked by video toother locations inthe trust.Staff discussed the number of patients waiting for beds, length of time patients were waiting in the emergency department and any breeches the previous day. Staff also discussed admission delays and the reasons for these.
- We were told by consultants and surgical staff that several groups of patients had no formally defined pathway, which impacted on their safety. They told us patients had been admitted under the wrong teams. Such patients were said to have included: An elderly patient with existing dysrhythmia, who fell and sustained rib fractures.
- We noted during our visit that surgical wards were used for medical outliers.For example on 21 October 2015, Evelyn Ward had 13 non-surgical patients receiving care.
- We were told by staff the Theatre Admissions Unit (TAU) was also used for overnight stays, despite it being a day surgical area. This was said to be as a result of there not being sufficient ward beds available when a patient needed to stay in.
- Pre-assessment was consultant led and there was anaesthetic presence in the department Monday, Tuesday, Wednesday and Fridays. A patient confirmed they had deferred their pre-assessment appointment and were able to re arrange this to suit them.
- Surgery was prioritised according to those who had the most urgent needs and there was access to a designated emergency theatre. We observed there was one emergency NCEPOD list and one trauma list per day. One NCEPOD theatre was accessible 24/7.
- Theatre lists were available from the Thursday of the week prior to surgery taking place. We were told by a consultant these lists were rarely updated with additional information, such as when a patient was to undergo an additional surgical procedure. They added that such information may have prevented the incident where a patient did not have all the required surgery as it had not been picked up by the person undertaking the consent.
- We saw a theatre utilisation report for the period July 2014 to July 2015, which indicated average utilisation at Northwick Park Hospital was 78%. We noted from updated utilisation figures a slight dip to 77.8% in August and for September an elevated rate of 79.3%.

Surgery

- We noted in minutes of the Theatre Users Committee meetings that utilisation and performancewas reviewed and discussed, with actions required identified.
- The percentage of patients whose surgery was cancelled and were not then treated within 28 days for the period April 2014 to March 2015 was less than 20%.In the first quarter of 2014 there were 24 patients who did not have their surgery rescheduled at Northwick Park Hospital within 28 days and in quarter two there were 13 patients.
- Data for cancellations on the day of surgery for hospital reasons indicated 162 patients had been cancelled between January and July 2015. Of the 4712 patients listed for surgery across this period, 384 patients cancelled or did not attend. The total number of cancellations was 546, representing 11.6%.
- A patient who spoke with us on Fletcher Ward told us they were expecting to go to theatre that morning and the surgeon had explained to them the reason for delay.Another patient explained that they had beenwaiting for three daysand a decision had yet to be made regarding surgery.
- A consultant anaesthetist spoke with us and explained the recovery bed capacity (15 beds) was often restricted by patients who were awaiting beds on the wards. The recovery policy required patients to be kept in the area for 45 minutes to an hour, but they had experienced patients staying much longer in the department, which created a “bottleneck” and prevented other treated patients entering recovery. This resulted in patients needing to be recovered in theatre.
- Information regarding surgical “outliers” on other wards was communicated in the bed capacity and safety huddle meetings. Staff were aware of patient locations and information was reported on electronic patient boards.
- Multidisciplinary meetings included discussion of patient discharge arrangements. We noted the performance scorecard for the surgical division indicated 9.8% of patient discharges happened before 11am in July 2015, with a year to date at the time of 12.46%.
- There was no formal data to indicate the number of discharges happening out of hours.
- The percentage of patients with a fractured neck of femur seen and operated on within 48 hours was 65.7%, against an England average of 73.8%.
- Average length of stay of patients who have elective surgery at Northwick Park Hospital was better than the England average for all types of surgery. The top three surgical specialities of colorectal, vascular and urology also had a shorter length of stay than the England average for the period January to December 2015, 5.5, 2.5 and 1.7 days respectively. (The England averagewas 6, 4.4 and 2.1).For non-elective surgery, the length of stay was worse for patients who had trauma and orthopaedic surgery, at 11.4, against the England average of 8.5 days and in vascular surgery 17 days, with an England average of 11.9 days.

Meeting people’s individual needs

- The surgical services were accessible to all, regardless of any disability. There was wheelchair access and arrangements could be made to facilitate communications where required. Single sex accommodation was provided on wards and there was access to separate toilet and bathing facilities.
- We did notfind any evidence to suggest discrimination, including on grounds of age, disability, gender, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation was involved in making care and treatment decisions. Staff went about their duties in an inclusive manner, afforded attention to each patient on an equal basis, as required.
- There were suitable arrangements in place for people with a learning disability, with access to a learning disability lead nurse and an extensive resource files. Carers and family were encouraged to be involved and passports were completed where able in order to provide staff with relevant information. Theatre schedules took into account where an individual would benefit from early an operation slot.
- Despite there being a trustdementia care strategy, we found there had been very little attention paid to the individual needs for people living with dementia. Whilst there was a dementia lead and nursing staff offered one to one support when required, the surgical wards had not made any alterations to the environment to make them dementia friendly.Individuals who were living with dementia were not identified,for example,through the use of ‘forget me not’ or similar indicator.
- The pre-assessment nurse who spoke with us reported having good links with the dietician, speech and language therapy team (SALT), Macmillan and breast care nurses. Mental health assessments were said to be

carried out at the actual admission. Where patients had other needs, such as those related to learning disabilities or cognitive impairment, pre-assessment staff sought information from relatives, carers or the GP. Any identified issues were said to be highlighted to the anaesthetist.

- We were told there was little bariatric work at the location and that patients tended to be known to the dietician already. Pre-assessment nurses told us they liaised with theatre in advance regarding equipment needs.
- Interpreters could be arranged for pre-assessment if known about in advance. In such cases, the schedulers were said to book the interpreters. If it was not known that an interpreter was needed, the patient would be re-booked to facilitate arranging this.
- Patients reported the nursing staff of being responsive to their needs, for example on Dowland Ward, a patient said the nurses were always coming in and out to check on them and came straight away if needed. One patient commented on the pressures staff were under and told us they thought the staff would like to have more time to spend with patients. A patient gave us an example of how responsive staff had been when the pain relief initially prescribed made them feel nauseous and was consequently changed. Other patients told us they had been given pain relief when needed.
- We spoke with a carer who expressed their gratitude in being allowed to stay with their relative outside of visiting times, although initially this had not been agreed. They had been able to calm their relative and assist with feeding in order to meet their relative's needs.
- Staff made suitable arrangements which took account of individual needs of people being discharged, including those who had complex health and social care needs requiring special considerations. The MDT discussed discharge arrangements and liaised with external agencies as required.
- A patient who was going home from one ward explained how they had been involved in planning their discharge and how the arrangements put in place had been responsive to their needs. For example, the provision of transport, carers and key safe access. They were aware they could not be discharged immediately prior to the weekend, as community services were not available at weekends.
- Patients who spoke with us generally commented positively on the quality of food and choices available. One patient told us they enjoyed the food and that there were plenty of choices, including being able to select a special diet. Another patient commented on not getting the food of their choice but added what they had received was good.
- A hostess who we spoke with told us they undertook a weekly survey to see what patients thought of the food. They told us how they engaged with patients in order to help them make decisions and choices. This staff member was able to use their multi-linguistic skills to ensure patient's nutritional needs were addressed.
- A patient who had been in hospital some time told us they would have liked a television but none were available. We noted too this patient was not able to reach their call bell and as they were reliant on staff, they may not have been able to summon help.

Learning from complaints and concerns

- Information was available to patients, including 'listening and responding leaflets', how to complain and details about the Patient Advice and Liaison Service (PALS). Patients who were asked about complaints knew how to raise one if they needed to do so.
- Complaints data was recorded as part of the patient expectations performance indicators. We noted from information reviewed complaints were logged by date and location, the type of complaints and outcome of investigation. Complaints information was also displayed on wards. For example, we noted there had been one complaint in the month on Evelyn Ward and none on Dowland Ward. Year to date there had been three complaints on Fletcher Ward.There had not been any complaints on Gray Ward.Numerous thank you and complimentary cards from patients were seen on wards.
- Staff told us complaints were openly discussed by ward managers and matrons. If necessary individual staff were required to write a statement as part of the complaints investigation process. They reported the importance of trying to resolve a complaint as soon as possible and making sure patient shad access to PALS.
- We reviewed written communications to complainants, which indicated a detailed approach had been taken. The letter included an apology and provided a formal record of the investigative process and conclusion.

Surgery

Are surgery services well-led?

Requires improvement

The governance arrangements were not fully reliable.Senior leaders had not reinforced the required safety reporting practices across the medical staff group and as a result some incidentswere notreported. Adverse incidents had not always been recognised and categorised correctly.Actual and potential risks at a service and patient level had not all been identified.

The development of the surgical directorate strategic aims was in progress and would need time to be embedded into practice.

Staff were aware of thevision of the trust anddemonstrated a commitment to delivering high standards across the surgical service and there was a culture of openness and transparency when things went wrong.

The ward and theatre staff reported favourably on their immediate line managers, their approachability and support andreported beingvalued and respected. However, medical staff reported a lack of visibility at board level and a lack of support.

There had been limited opportunities for patients to contribute to the running of the surgical service, although they were able to feed back on their experiences.

Vision and strategy for this service

- We spoke with the divisional leads for the surgical directorate about the service strategy. We were informed there had been several workshops around the development of a strategy, which had included post-merger meetings with surgeons and anaesthetists to discuss where services should be. Most of the aims were said to have been achieved, such as moving services within the separate locations. For example, the majority of gynaecology services had moved to Ealing Hospital in order to strengthen their services.
- Information provided to us demonstrated the head and neck directorate had outlined their current services and future plans in a formal document for the period 2013/18. The content therein indicated the focus on establishing and branding an integrated head and neck hospital on the Northwick Park Site. Plans were to set up four additional full day theatre operating slots to be used between Maxillo facial and ENT, restructure Gray Ward staffing and facilities to skill up the nurses to manage a six bedded Head and Neck HDU. In addition, they planned to appoint a further three ENT Head and Neck Cancer Surgeons and one further Maxillofacial Trauma Surgeon.
- The surgical strategy had been discussed as a regular agenda item within theatre users committee meetings. We reviewed a number of these minutes and saw, for example, minutes for30 June 2015, it was noted there had been slow progress on the strategy, but that the aim was to consolidate surgical work, with NPH the acute, 'hot' surgical site in the trust, with movement and concentration of specialties doing surgery on fewer sites.

Governance, risk management and quality measurement

- We spoke with the divisional leads for the surgical services who were able to confirm the governance arrangements,including staff structure andmonthly speciality meetings.
- The surgical directorate was overseen by a divisional clinical director, general manager and head of nursing. There were two divisional governance co-ordinators and one designated service improvement lead. Staff holding these roles were clear about their responsibilities and understood what they were accountable for.
- A range of speciality clinical governance meetings took place as follows: A head and neck team meeting was held on aTuesday. The head and neck directorate services also met on a Friday, the trauma and orthopaedic directorate meeting was held twice a month on Tuesdays, weekly matron meetings on a Tuesday, the Theatre Users Committee, held monthly and Clinical Incident Review Group, on a monthly basis. Meeting minutes demonstrated that risk management, audit, incidents and other quality and safety matters were discussed, with contributions from respective areas.
- The governance framework was designed to support the delivery of surgical services and good quality care. This included monitoring clinical performance and patient experience, together withaudit and risk, which fed into respectivecommitteesand to the trust board. Despite this we identified aspects of the governance arrangements that were not sufficiently robust.

- The performance management data collected for surgical services included a range of areas, such as patient safety and the patient's experience. Performance indicators were reported monthly and were reviewed as part of the governance processes. However, the reporting of some incidents was not always happening and, as a result, there was a possibility of missed opportunities to improve outcomes. In addition, there was a lack of understanding around the categorisation of incidents.We found a never event had occurred as a result of patient investigative results having been mixed up, with the result that a patient had unnecessary surgery (at another hospital).This was reported and investigated as a serious incident.
- We reviewed the surgical risk register and found this identified risk by specialty, type and attached a risk rating. A responsible lead was assigned and the risk management plan had been summarised and progress noted. We noted capacity issue described around the NCEPOD theatre, lack of theatre times and pre-assessment. We also identified risks described with regard to the flow issues that impacted on the use of the recovery department. However, we did not identify risks related to the non-reporting of incidents or issues related to lack of patient pathways or access to weekend consultant radiologist.
- There was a multidisciplinary medicines safety forum and medicines incidents were discussed at this forum, and learning was shared across staff pharmacy and nursing staff in a variety of ways. This included; emails, handover meetings, medicines bulletins, information published on the intranet.
- Senior nurses who spoke with us in a focus group meeting reported, since the appointment of the new CEO, changes in risk management and governance structures had given them more assurances. For example, the structured reporting via dashboards and key performance indicators (KPIs)were betterin terms of cost savings. Theysaid the direction of travelhadimprovedwith respect to reporting safety, quality and the patient experience.
- We found, from our discussion with staff and review of formal information, there were various quality measures in place. This included focus on continuous improvement in infection prevention and control, including accountable leadership, multi-agency working and the use of surveillance systems.

Leadership of service

- Nursing staff on wards reported they werevery well supported by ward managers and matrons. We were told about the supportive mechanisms in place for less senior staff. For example, the pre-assessment nurse told us healthcare assistants had meetings with band six nurses. Where matrons were not on-site, such as the pre-assessment matron, they were visible and made sure they checked on staff and the department.
- Other comments made to us about leadership included feeling well supported, being enabled to ask questions and having ideas and suggestions listened to.Delegation was said to be done well on Edison Ward and guidance was provided, along with feedback in a respectful manner.
- A band seven theatre nurse told us they did not feel supported by their managers, whilst junior doctors told us they were very well supported and the consultants and SpR's were very hands on.
- During our discussion with a number of consultants, they told us the board level management were not visible and unsupportive, with the exception of the Medical Director. They added decisions were made and policies enforced without the backing of the teams, for example, they have been told to conduct bi-weekly M&M meetings, but did not have the time to facilitate them. Further, they did not have protected handover time, despite presenting evidence showing they should.
- Staff confirmed they received weekly communications from the Chief Executive Officer.

Culture within the service

- The surgical leadership team reported to us an open culture between themselves, with regular weekly meetings to discuss issues. They told us they promoted an open approach to their managerial style, which included sensitivity when dealing with performance or other issues such as complaints.
- Our observation of staff/patient interactions and working practices indicated the culture at Northwick Park Hospital centred on the needs and experiences of people who were using the services. For example, staff did their best to work collaboratively in providing the

treatment and care expected by patients and their families. Where things did not go as planned or expected, staff were prepared to apologise, acknowledge and learn from the investigative process. The culture encouraged candour, openness and honesty and we saw evidence of this in written responses to individuals affected by the matter.

- Staff told us the culture was open, encouraged sharing and action planning to make improvements. A nurse told us "I feel proud if I am able to respond to the needs of patients." A relatively new healthcare assistant told us the staff all worked well together and theywere able to approach more senior staff.
- Sickness absence was monitored for each area and we were told by a member of nursing staff they were supported with regard to recent sickness absence they had taken.
- We observed staff and teams working collaboratively in order to ensure the deliver good quality care. Many staff had been at the hospital for a number of years and we were told by a number of staff they had good opportunities for training and development, as well as to advance in their career. For example, one staff member told us they started as a healthcare assistant and had progressed to operating department practitioner. One staff member with 42 years' service reported loving their job and we observed happy and cheerful interactions between this person and their patients.
- Staff meetings were reported by nurses to be open and enabled issues to be raised and discussed. Many staff had worked at the location for a number of years and it was said to be a "happy place to work." A band six nurse commented on feeling able to act in the same way towards junior staff as they were treated. They told us theywere valued and respected by the organisation, much more than their previous place of work. This nurse told us there was no discrimination or bullying and that overall the service acknowledged the multi-cultural diversity of staff and service users.

Public engagement

- We asked nursing staff if there was any public engagement taking place to gather their views and help shape the services. There was no awareness of such engagement and further we did not see any specific information related to the hospital location in pre-inspection literature provided.
- We noted feedback from patients and their families was gathered through the Friends and Family Test. In addition the wards had 'you said, we did' boards and information was recorded on these.

Staff engagement

- Staff generallywere engaged and told us they could share their ideas and suggestions.The directorate managers told us staff had been invited to contribute to the development of the surgical strategy, and several workshops had been held.
- The sisters meeting was reflected on by staff as a good opportunity to understand what other teams and individuals were doing. They also provided an opportunity for peer support and sharing information.
- We reviewed the staff survey results gathered in March 2015. The percentage of staff who strongly agreed they were happy in their work ranged between 44% on Edison Ward, 65% on Gray Ward and 60% on Evelyn.In response to feeling part of a strong team with a good team spirit, the percentage of staff who strongly agreed ranged from 38% on Edison Ward,53% on Evelyn Ward to 70% on Gray Ward.
- As part of the nursing recruitment and retention strategy the trust was committed to maintaining effective staff communication at all levels and ensuring staff involvement was maintained at all levels. A staff involvement policy and charter had been developed in partnership with staff to support this aim.
- Wereviewedthe action plandeveloped from the results of the most recent staff survey. The actions related to mandatory training, appraisals and bullying.

Innovation, improvement and sustainability

- We observed evidence which indicated acknowledgement of improvements to quality and innovation had been recognised and rewarded. For example on Gray Ward we saw a certificate of recognition displayed for excellence in mentoring.
- There was full awareness within the surgical directorate lead team of the problems related to patient flow, particularly around delays in moving patients out of theatres and through recovery. This was identified on the risk register, with actions stated to include;

monitoring including, daily audit of recorded delays, daily executive bed meetings and evidence of theatre delays presented at the directorate governance meeting.

- We were told about the 'Braking the cycle' programme, which was planned to start in November.
- The surgical leads were proud of the level of clinical engagement and in particular how this had enabled the pace of change to take place relatively smoothly. They singled out the head and neck services and recognition of the service as a leading tertiary provider, which included training with respect to surgical specialties.

Critical care

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

Information about the service

Critical care at Northwick Park Hospital is delivered across four units and comprises of 25 beds. The critical care service looked after patients requiring level two care (patients requiring more detailed observation or intervention, single organ failure or postoperative care) and level three care (patients requiring advanced respiratory support alone or basic respiratory support and support of another organ).There is an Intensive Therapy Unit (ITU) which accommodates 11 levelthree patientsand a three-bedded Overnight Intensive Recovery (OIR) which also cares for level three patients. Level two postoperative patients are cared for within the Elective High Dependency Unit (eHDU) which has five beds and level two medical patients are accommodated onthe Dryden High Dependency Unit (HDU). Level two patients were cared for on the Coronary Care Unit (CCU) and in recovery? but these areas are reported on in the medicine and surgery reports respectively.

Patients are admitted to critical care after becoming unwell on the hospital wards, via the accident and emergency department or after surgery. A critical care outreach team is available to assess deteriorating patients on the wards and to follow up patients who have been stepped down from critical care

We visited all areas of critical care over the course of three announced inspection days. During our inspection we spoke with 52 members of staff including doctors, nurses, allied health professionals (which includes physio and occupational therapists, pharmacists, dieticians and speech and language therapistsandadministration and ancillary staffas well as the critical care leadership team.We spoke with 11 patients and six relatives. We checked 18 patient records andmanypieces of equipment.

Critical care

Summary of findings

The critical care service requires improvement. Medical staffing on eHDU was not sufficient and care was provided by anaesthetists without critical care accreditation. Additionally, less than the recommended proportion of eHDU nurses had critical care qualifications. The provision of pharmacy staff within critical care did not meet recommended standards and multi-disciplinary working was variable across the service. There was little shared learning across the service or with other specialities within the hospital and a limited relationship with the critical care team at Ealing Hospital.

The critical care environments were not compliant with HBN0402 building notes and compliance with infection prevention and control measures was variable. Patient outcomes were not as good as those at similar units nationally and other local units. There was a high occupancy rate throughout critical care and there had been some elective surgery cancelled as a result of this. There were significant numbers of non-clinical transfers as well as out of hours discharges as a result of critical care bed shortfalls. Senior staff were aware of these issues and had sent reports with relevant data to the senior management team,however no steps were in place to address the shortfall in critical care beds.

There was a positive culture across critical care and a good clinical leadership presence. Managers within the service were aware of the risks on the individual units and these concerns were reflected on the relevant departmental risk register. There was an obvious desire to improve the quality of care delivered. Results from the Friends and Family Test and our Short Observational Framework for Inspection (SOFI) were positive and we received complimentary feedback from patients and relatives throughout the service. The service respondedto any negative feedback from patients and their visitors proactively.

Are critical care services safe?

Requires improvement

Safety across critical care required improvement as there was an increased risk of patient harm. There waslimitedmedical cover on eHDU out of hours and at weekends, which meant there was frequently no doctor immediately available on the unit. Consultants responsible for eHDU and Dryden HDU were not intensivists and processes for escalating surgical patients were unclear. Provision of pharmacy staff did not meet recommended levels and no pharmacist was in place for patients cared for in the OIR.

The critical care environment was not compliant with HBN0402 building notes and infection prevention and control measures, including use and disposal of personal protective equipment and barrier nursing measures, were not consistently adhered to. We noted some incorrect management of needle sharps bins and old blood spots on the blood gas analyser machine.

There was generally a good incident reporting culture although some staff were unclear about the need to report near-misses and some root cause analysis lacked sufficient details or action points. Staff received feedback and learning points after incidents were reported. Patient risk assessments were completed at appropriate intervals. Safety thermometer performance was good and mandatory training was up to date for most staff. Staff knowledge of safeguarding was good and staff completed referrals when indicated.

Incidents

- Incidents were reported via online forms which could be accessed by all staff and completed on any trust computer. Between September 2014 and August 2015, there were 392 incidents reported across critical care at NPH; 261 incidents were attributed to ITU, 122 were attributed to eHDU and 9 were attributed to Dryden HDU. Any incidents involving the OIR beds were reported under theatres and recovery which meant no specific information was available for incidents which had occurred in this area. There wasoneserious incident and no never events reported throughout critical care

during this period. Serious incidents known as 'Never Events' are largely preventable patient safety incidents which should not occur if the available preventative measures had been implemented.

- Staff across critical care knew how to report incidents and were able to identify the types of situations which would trigger the completion of an incident form, however some staff did not think it was necessary to report near-miss situations. Staff told us they tried to make sure all incidents were reported but it could be difficult to find time for this due to busy shifts.
- We saw evidence demonstrating investigation into incidents took place via root cause analysis (RCA) which involved all relevant people in the investigation process. However some examples of RCAs we were shown lacked sufficient detail and clear documentation of any action or learning points. Senior staff told us learning points were disseminated amongst ward staff via handovers, staff meetings and information posters. They also sent staff emails highlighting specific learning points to reinforce the information provided face to face.
- Staff told us they received feedback about incidents within their unit and learning points were communicated via team meetings and handovers. Staff told us regular clinical governance information sessions were held which they were encouraged to attend.However theytold us feedback about incidents in other areas of critical care or the wider hospital was limited to only to serious events which changed hospital policy.
- The Critical Care Incident Review Group met monthly to discuss incidents which had occurred on ITU at Northwick Park Hospital and Central Middlesex Hospital and any learning points which could be carried forward. There was no involvement from staff responsible for other areas of critical care within Northwick Park Hospital or from Ealing Hospital.
- Clinical governance information sessions were held by senior ITU staff three times per year with topics such as safety, quality measures and morbidity and mortality reviews. Ward staff told us they were actively encouraged to attend these meeting by senior staff and the meetings were useful.
- Morbidity and mortality meetings were held alongside the weekly MDT meeting on ITU. Minutes from these meetings demonstrated discussions relating to patient deaths on the unit, including whether any critical care involvement could have been improved.
- Governance of incidents as well as morbidity and mortality meetings within the HDU areas of critical care were the responsibility of the division under which the unit was placed; governance on Dryden HDU was the responsibility of the medicine division and eHDU/OIR governance fell under surgery and theatres.
- Most senior staff across critical care could identify and describe principles relating to duty of candour requirements. Junior staff had some knowledge relating to this but told us senior ward staff would lead the process of incident investigation and communication with patients and their families.
- We saw evidence of letters to patients and relatives regarding clinical incidents which had occurred on the unit, fulfilling duty of candour requirements.These letters identified what incident had occurred, any potential and actual consequences of this occurrence and learning points identified. Letters also included an apology to the relevant party.

Safety Thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. Safety Thermometer and staffing details were displayed at the entrance to each critical care area. Safety thermometer data detailed below refers to the period October 2015 to September 2015.
- There were 12 unit-acquired pressure ulcers reported within ITU, two unit-acquired pressure ulcers on Medical HDU and eight on eHDU.No trends were identified regarding the cause of the unit-acquired pressure ulcers. During our inspection, we saw patients' risk of developing a pressure ulcer was assessed using Waterlow Pressure Ulcer Prevention Score throughout critical care. There was a staff nurse identified as a tissue viability link nurse on ITU and Dryden HDU. Staff were able to correctly describe how to calculate this score and we saw evidence it was used at regular intervals. We observed different types of equipment such as special seat cushions and mattresses had been ordered for patients at high risk of pressure ulcers.

- Catheter care bundles were used throughout critical care and there had been no instances of CUTIs during the data period specified.
- There were no falls with harm to patients in intensive care during the reporting period. We saw evidence falls risk assessments were completed and mobility assessments were completed by physiotherapists were necessary.
- VTE assessments were recorded on the daily care chart and we saw these had been completed each day.There were no new VTEs within intensive care during the reporting period. Hospital audit data demonstrated 100% of patients were assessed for VTE risk at appropriate intervals during their admission to ITU, eHDU and OIR; this was in line with National Institute for Health and Care Excellence (NICE) quality standards.

Mandatory training

- General mandatory training (such as fire safety) was delivered as part of the trust's generic induction process. Refresher courses and role specific mandatory training needed to be booked separately and was the responsibility of each individual to organise.
- Most mandatory training was delivered on e-learning systemsbut some modules were completed via face to face training sessions. Staff were positive about their experiences of mandatory training andsaid it prepared them to fulfil their role adequately.
- Staff were able to complete their mandatory training during working hours, with time off the ward allocated in order to complete this. Staff told us their mandatory training was reviewed by their appraiser during one to one meetings as well as appraisals and they were encouraged to keep up to date.
- Mandatory training across critical caremostlyhad good uptake with more than 90% of critical care staff up to date in most key subjects, such as basic life support, safeguarding children level two, safeguarding adults level two and equality, diversity and human rights. There was low (less than 80%) compliance in clinical infection control training and information governance.

Safeguarding

- A trust safeguarding policy was in place and this was available for all critical care staff to view on the intranet. Staff were aware of the policy and most knew who the trust's lead safeguarding contact was.
- Safeguarding Adults level two training had been completed by 94% of critical care staff and safeguarding children level two training had been completed by 92% of staff. The completion rates for this training were better than the average uptake across the hospital.
- Staff across critical care told us all patients were considered for safeguarding referrals on admission to critical care and were able to identify triggers which would make them complete a referral. Staff on Dryden HDU were able to provide specific examples where safeguarding referrals had been triggered. We saw evidence of completed safeguarding referrals on ITU and Dryden HDU.
- Multidisciplinary critical care staff including physiotherapists and pharmacists had sufficient safeguarding knowledgeand they told us they would independently instigate a safeguarding referral for a patient if this hadn't been completed by ward staff.

Cleanliness, infection control and hygiene

- A member of housekeeping staff was allocated to ITU for the whole day plus one additional hour in the evening. In the smaller critical care areas,housekeeping staff were shared with the adjacent ward, for example,the housekeeper who covered Dryden HDU also covered Dryden ward. Out of hours, housekeeping support was available via a bleep system.
- Housekeeping staff used colour coded cleaning equipment to limit the risk of cross contamination between clinical areas, for example yellow cleaning equipment was used in isolation or barrier nursed areas.
- The critical care areas weremostlyclean; although we noted the doctors' office and relatives' waiting room on ITU had remnants of food and other debris on the floors. Monthly cleaning audits were completed by the housekeeping supervisor and nurse in charge throughout critical care.Recent results showed the cleanliness of ITU scored 97.09%, which was slightly below the 98% target. Action points were identified and we saw evidence demonstrating they were checked for compliance with cleaning standards once corrected.
- Staff told us bedside equipment such as the ventilators and drip pumps were cleaned by nursing staff and we saw this taking place during our inspection. Bedside equipment we checked was clean,however some items in storage areas were not, for example some therapy equipment.

Critical care

- We inspected commodes throughout critical care and noted they were clean including the underside of the seat, support legs and foot plates. Staff told us commodes were deep cleaned regularly and we saw documentation which showed this occurred on a weekly basis.
- Where possible,side rooms were used to accommodate patients who required barrier nursing. Staff told us a 'hierarchy of use side room use policy' was in place to indicate which conditions or infections should take precedence over others. The location of barrier nursed patients who were not able to be nursed in a side room were risk assessed and positioned with a 'barrier nursing' warning sign immediately outside their bed space.
- Few of the side rooms available for barrier nursed patients had separate decontamination lobbies which is not compliant with best practice guidance or HBN0402 requirements and increased the risk of cross contamination.
- We observed several warning signs in use on side room doors and at the entrance to patient bed spaces to highlight when patients were receiving barrier nursing. On one occasion we were informed a patient was being barrier nursed,however we noted no sign was in place to identify this. This meant ward and visiting staff may enter the bed space without wearing necessary personal protective equipment (PPE) and increase the risk of cross contamination. We also observed the ward portable telephone was passed to a nurse within a barrier nursed side room and noted the telephone was not cleaned before being placed back onto the charging cradle at the nurses' station.
- Hand washing facilities and alcohol gel were available at the entrance to all critical care areas and there were signs in place reminding visitors to clean their hands before entering. There were adequate hand washing facilities throughout the units and alcohol gel was available within each critical care bed space.
- A full range of basic PPE including aprons and various sized gloves were available within each bed space or bay area. Additional PPE such as masks and visors were available within storage areas of the units. We noted ward stocks and provision in the clinical areas of critical care were frequently replenished.
- We observed staff washing their hands with soap and water or using alcohol gel prior to and immediately after episodes of direct patient care. This practice was in line with the requirements of NICE quality standard 63.
- Hand hygiene audits were completed on a monthly basis across all areas of critical care. Staff told us these audits were usually completed by the nurse in charge,however they were sometimes delegated to other members of staff. Between May and July 2015, hand hygiene compliance was seen to be an average of 93% on ITU and 100% on eHDU.
- We observed staff correctly using PPE like gloves, aprons and visors to complete patient related tasks such as intimate care and tracheostomy suctioning. The majority of staff correctly removed their PPE once the task was completed and before leaving the patient bed space.However we noted some staff did not remove PPE or clean their hands before entering the main ward area. We noted some incorrect disposal of PPE; this should be discarded in clinical waste bins but were seen to be placed in the general domestic waste.
- Most staff adhered to 'bare below the elbow' protocols and wore short sleeve tops and no jewellery or watches. However, we noted a member of security staff closely supervising a patient for several hours whilst wearing long sleeves and a watch without being challenged by ward staff.
- Disposable curtains were used between bed spaces and were seen to be labelled with the date they were put up. Staff told us they were changed every four months or sooner if they became soiled or if a barrier nursed patient had been cared for within that bed space. Bedside curtains we inspected were seen to be clean.
- There were two cases of hospital attributed Colostrum Difficile (C. Difficile) within critical care between April and July 2015.Both of these occurred on Dryden HDU within the same month and staff told us the resultant RCAs demonstrated these were unrelated.Intensive Care National Audit and Research Centre (ICNARC) data showed occurrence of C. Difficile within ITU was better than in other similar units between January and June 2015, as there were no unit-acquired cases.
- Patients were swabbed for methicillin-resistant staphylococcus aureusis (MRSA) on admission to ITU, eHDU and hospital audit data showed 100% of patients

were swabbed between April and July 2015. ICNARC data showedthere were no cases ofunit-acquired MRSA andperformance in this area was better than in other similar units.
- ICNARC data demonstrated unit acquired blood stream infections on ITU occurred more frequently than on other similar units. Hospital audit data showed 88% compliance with best practice guidance on IV line insertion and 91% compliance with ongoing IV line care. Results for eHDU were 100% for insertion as well as ongoing care.

Environment and equipment

- Critical care was provided within four different units in the hospital. ITU provided care for up to 11 level two and three patients within three single rooms and four two-bedded bays (11 patients in total). eHDU could accommodate five level two patients including two single rooms and the OIR could accommodate three level three patients within the theatres recovery area. Dryden HDU cared for up to six level two patients within a four-bedded bay and two side rooms.
- None of the critical care ward areas were compliant with HBN0402 critical care environment requirements due to bed spaces being smaller than the recommended size. Additionally there was a lack of decontamination lobbies for true barrier nursing within side rooms andlimitedavailability of positive or negative ventilation.
- Black general waste and orange clinical waste bins were located throughout the critical care areas in appropriate places, for example the general domestic waste bins were available at handwashing sinks and the clinical waste bins located in each patient bed space.None of the general or clinical waste bins were seen to be overfull and we noted waste was removed from the wards throughout the day. However we found some waste bins were difficult to access due to storage of equipment or the location of the bin under sinks.
- Needle sharps bins were provided at appropriate places throughout critical care, such as in medicines preparation areas and at patient bed sides; most were labelled correctly. We noted one sharps bin at the nursing station on eHDU was filled above the maximum fill line and had scissor blades protruding through the sharps insertion hole and we found another bin on ITU which was also filled above the maximum fill line.
- Arterial blood gas analyser machines were available on ITU and within the OIR area. We noted spots of dried blood on one machine and on the surrounding worktop. We raised this concern with the matron who ensured the issue was addressed and a reminder to keep the area clean was given to staff. Throughout the remainder of our inspection, we noted the machine was kept clean
- A resuscitation trolley was available within or immediately outside each critical care area. Each trolley was secured with a plastic lock which was broken when access to the equipment was needed or for equipment checking. Documentation demonstrated the resuscitation trolleys were checked on aweekly basisand there were no gaps on the checking documentation.
- Adifficult airway trolley was located on ITU and we found the contents did not reflect the current guidance from the Association of Anaesthetists of Great Britain and Ireland (AAGBI) . This concern was raised with the unit matron who initiated an immediate review of the contents which was on going throughout our inspection.
- Consumables across critical care were kept in storage cupboards containing labelled shelving and drawers. All equipment we checked was seen to be in date and staff told us there were rarely issues relating to the availability of consumables.
- Medical equipment was maintained by staff employed by the trust to manage safety testing and day to day functioning issues. Most equipment was replaced via afiveyear replacement programme and funds for replacing capital equipment had to be obtained via submission of a business case.
- We noted equipment across critical care was up to date with portable appliance testing (PAT) and a date for the next service was identified on each item.
- Records of medical equipment training were shown to us and these demonstrated critical care staff had undergone basic training and additional follow up training on certain pieces of equipment.

Medicines

- Pharmacy cover on ITU and eHDU was provided by 0.5 whole time equivalent (WTE) critical care pharmacists. Dryden HDU received pharmacy support by the pharmacist responsible for Dryden Ward, who had not completed additional critical care training. There was no pharmacy cover for patients within the three OIR beds and this was recorded on the departmental risk register. A hospital-wide on call pharmacist was available out of

hours for queries and emergency stock requests. Pharmacy provision across critical care did not comply with recommendations from the Faculty of Intensive Care Medicine Core Standards.

- A dedicated "prescribing zone" was identified in ITU where doctors could sit to write prescriptions without being disturbed. Senior staff told us this was set up with the intention of reducing the risk of prescribing errors;however the effect of this protected area had not been audited.Prescribing guidance was provided within the "Introduction to ITU" booklet which was provided to all doctors who were new to the unit. Additional prescribing guidance could be obtained from copies of the 'British National Formulary' which were located at the desk.
- Medicines administration charts contained full details of patient allergies, including the medicine name and reaction caused. We observed evidence medicines charts had been reviewed by a pharmacist and relevant comments had been annotated on the charts as required.
- All medicines administration charts we checked were legible and had been fully completed, including reasons for any omissions. We noted antibiotics were prescribed in line with guidelines.
- Medicines across critical care were stored in lockable wall cupboards, which we noted were kept secure when not in use. Keys to access the medicines cupboards were either carried by the nurse in charge of the unit or were stored in a keypad locked storage box. Various systems were used to organise medicines storage within critical care, for example ITU stored medicines in alphabetical order.
- Medicines were stored in lockable fridges when appropriate and temperature checks were completed on these daily. Documentation demonstrated some gaps in temperature checking (for example seven gaps in September for the medicines fridge on ITU) and there was not always evidence of action taken when the fridge was seen to be outside the optimal temperature range.
- The ITU medicines fridge had a stock list stuck to the front door which identified which medicines could be found in the fridge and which shelf they would be on. We noted the actual location of many medicines did not correlate with the position identified on the stock list; for example glucagon should have been stored on shelf two but was found on shelf four. We also noted insulin was stored in a plastic container labelled "analgesics". These concerns were raised with the ward pharmacist who addressed the issues with the medicines fridge storage.
- Controlled drugs (CDs) were stored in a separate lockable cupboard and required two nurses to be present for these medicines to be prepared and administered to patients. We observed nurses throughout critical care administering CDs and following the correct processes, including medicine preparation and administration.
- The contents of the CD cupboard were checked on a daily basis during the nightshift by the nurse in charge and another registered nurse. The CDs were checked against the CD book and all entries were signed by both members of staff. During our inspection we noted the oral morphine had no opening date recorded which is not in line with best practice guidance.
- We observed a porter delivering CDs to ITU and the correct process was completed with regard to handing over the medicines to a suitable member of staff, contents checked by nurses and signed off prior to the porter leaving the ward, and new items recorded in the CD book.
- We noted portable oxygen was available throughout critical care and all canisters checked were seen to be in date. Oxygen canisters were stored in designated racks throughout.
- Medicines management audits were completed throughout critical care on a monthly basis by pharmacy staff. ITU compliance ranged from 92-100% compliance and eHDU was consistently 100% compliant
- Medicines incidents were reviewed by the ITU pharmacist alongside the ward matron and pharmacy link nurse. An audit completed by the pharmacy team demonstrated a 48% reduction in medicines errors between November 2014 and July 2015, as a result of training and feedback provided to ward staff.

Records

- Paper records were used throughout the critical care service and we noted several different critical care nursing documents in use. Most entries we reviewed were legible and had been signed and dated appropriately. We noted some records had loose sheets of paper which had not been filed and could be easily lost when moving the patient's notes.

- Daily care records documented measurements of patient observations and various assessments as well as holistic information such as family discussions and details of the patient's mood. Additional nursing documentation was also completed and this was stored in a folder at the patient bed space.
- Medical notes were stored in a separate folder at the patient bed space. Details of ward rounds, care plans and reviews by visiting medical teams were recorded.
- We reviewed records throughout critical care and we observed most were fully completed, although there were some omissions such as diagnosis on admission.
- NICE CG50 guidance states there must be documentation demonstrating when the decision to admit patients to ITU was made and hospital audit data from July 2015 demonstrated this was present in 70% of patient notes which corroborated our findings on inspection.

Assessing and responding to patient risk

- Staff told us patient risk of Venous Thromboembolism (VTE) was assessed on admission and then again at 24 hour intervals. We saw evidence demonstrating patients had been assessed at the specified intervals within all patient records we reviewed and hospital audit data demonstrated consistently more than93% compliancewith VTE assessment across critical care in July and August 2015. The national target for VTE assessment compliance is 95%.
- According to trust policy, the Confusion Assessment Method for the ITU (CAM-ITU) was used to assess whether patients were delirious whilston the unit. This practice was in line with current best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. We observed this assessment had been completed with appropriate patients on ITU.
- Manual handling risk assessments were completed for patients with unusual or complex manual handling requirements, for example bariatric patients and those who used specific equipment such as standing hoists.
- Patients who displayed challenging behaviour were cared for on critical care by a designated "special". A "special" was a supernumerary member of staff who worked solely with that patient and alongside the patient's regular bedside nurse. On ITU we observed use of a "special" staff member as well as support from hospital security personnel.
- Throughout the hospital and within the HDU areas a National Early Warning Score (NEWS) was calculated whenever the patient's observations were taken; this was in line with guidance from the Royal College of Physicians. The purpose of NEWS was to enable early identification of patient deterioration, as indicated by their observations. Patients scoring five or above were referred to the critical care outreach team for review to consider transition to or escalation of critical care.Some staff expressed concerns at the lack of formal escalation process for surgical patients who deteriorated on eHDU aside from the support provided by the outreach team. They were concerned because eHDU was not managed within the same structure as ITU and staffsaid the process of escalationwas not established, leaving patients at risk of being missed.
- Faculty of Intensive Care Medicine Core Standards for Intensive Care Units state patients should be transferred to ITU within four hours of the decision to admit. Hospital audit data from July 2015indicated 57% of patients were admitted within the four hour time frame, 11% were admitted after four hours and the time for the remaining 32% of patients was not documented. Staff had been reminded of the need to document the time of decision to admit to critical care to assist the audit process.
- The critical care outreach team was available 24 hours per day, seven days per week and were responsible for reviewing deteriorating patients as well as those who had recently been discharged from ITU. Staff told us patients discharged from HDU were not routinely followed up.Between September 2014 and August 2015, 3490 reviews were completed by the team concerning 1920 patients.

Nursing staffing

- There were three matrons responsible for the critical care areas within the hospital; a matron for ITU, a matron responsible for recovery (which included the OIR bed and eHDU) and a medicine matron responsible for Dryden HDU.
- Nursing staff worked shifts from 8am to 8:30pm and overnight from 8pm to 8:30am. Handovers were completed at 8am and 8pm each day and comprised of a general overview of all patients on the unit from the

shift leader before nurses received specific bedside handovers for their allocated patient/s. This ensured patients were cared for by safe levels of staff even during shift changeover times.

- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that all ventilated patients (level three [L3]) are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and for level two (L2) patients a ratio of 1:2. Units within critical care used an acuity tool to assess the required staffing levels. Records we reviewed demonstrated all areas of critical care were consistently staffed at the required levels to meet the recommended nurse to patient ratios. Staff told us patients being nurses in a side room would “almost always” be allocated a nurse on a 1:1 basis, even if they were a L2 patient.
- Each critical care area had a band seven shift leader who was supernumerary and not allocated a patient. The remaining staff were a combination of band five or band six registered nurses and health care assistants. Staff responsible for compiling the nursing rota were aware of the need for an appropriate skill mix and tried to ensure a 50:50 split of band five and band six nurses on duty within ITU. The off duty rota demonstrated this was achieved during most shifts. In other areas of critical care, the skill mix was less formulaic however it demonstrated sufficient band six nurses were rostered to support their band five colleagues.
- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends no more than 20% agency staff usage per shift. Documentation we reviewed demonstrated use of agency staff within critical care was compliant with this standard; between May and September 2015 agency staff made up between 5-12% of registered nursing staff on duty.
- The critical care outreach team was staffed by three band seven nurses and three band six nurses. Senior ITU staff were used to fill any gaps in the rota once they had completed the required competencies. A business case had been approved to increase the WTE of outreach nurses however recruitment for this was on hold while reviews of nursing establishment levels following the merger were undertaken by the trust.

Medical staffing

- Some aspects of the medical provision across critical care were not compliant with the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units; for example use of consultants without critical care accreditation and lack of consultant presence in some areas over weekends.
- An allocated critical care consultant was responsible for the ITU for seven days from Monday morning. The consultant worked from 8am to approximately 8pm each day, completing twice a day ward rounds including at weekends. The ITU consultant was supported by a registrar and a minimum of two senior house officers. Out of hours ITU care was led by aregistrar with advanced airway skills and supported by a senior house officer.
- The eHDU area and three OIR beds were led by a dedicated anaesthetic consultant for periods of seven days at a time. There were five consultants on the eHDU/OIR rota from the theatres anaesthetic team, none of whom had critical care accreditation. The consultant on duty worked from 8am to approximately 6pm Monday to Friday and was available on call over the weekend for telephone advice. Outside of these times,cover was provided by the on call anaesthetic registrar who was also responsible for managing emergency theatre cases. Staff told us the on call doctor was often very busy which left the eHDU and OIR with no doctor present. This was inappropriate staffing cover for the type of patients admitted as the unit did not only care for postoperative patients; there were also patients who had not been to theatre but required level two care and also patients stepped down from ITU. These patients would be classified as HDU patients and so staffing should reflect therecommendations from the 'Faculty of Intensive Care Medicine Core Standards.Staff explained there had been no incidents as a result of this,however senior medical staff were aware of the risk this carried. Registrars we spoke with told us,in their opinion,this was unsafe staffing provision but this concern had not been escalated.
- Handovers to the consultant taking over care of eHDU patients on a Monday morning was completed by the weekend on call anaesthetic registrar rather than a consultant to consultant handover. Staff highlighted this as a concern as there wasa risk important information could be missed.However no specific incidentshad been reported.
- The consultant covering eHDU was supported by a Foundation Year 1 (FY1) doctor who was allocated to the unit for a period of two weeks. This doctor worked

under the close supervision of the consultant and was not able to make independent decisions about patient care.The FY1 was not involved in the care of the OIR patients as they were considered to be "too acute" for their level of experience, even with close supervision from the eHDU consultant.

- Dryden HDU was the responsibility of an allocated medical consultant who was dedicated to the HDU. There were five consultants who covered Dryden HDU and none of these consultants had critical care accreditation. The consultant was supported by the medical registrar on call who was also responsible for responding to the medical emergency team bleep. Out of hours cover was provided by the on call medical registrar.

Major incident awareness and training

- Major incidents action cards were located across critical care, highlighting what actions were required by the team in the event of a major incident. Actions included calling in additional non-duty staff, monitoring stock levels of critical equipment and reviewing bed availability. Shift leaders were aware of these cards and could locate them on the critical care units.
- Generator testing was completed on a weekly basis throughout the hospital and staff told us ITU, eHDU and OIR received a priority power supply due to the nature of patients on the units. Staff within Dryden HDU were unclear what provision would be made for their patients in the event of a power cut, although they told us patients reliant on non-invasive ventilators were cared for on machines which could be battery powered in case this happened.

Are critical care services effective?

Requires improvement

Care provided across critical care was not effective and required improvement.There was inconsistent involvement of the multidisciplinary team across critical care and variable liaison with other areas of critical care in the trust. Patient outcomes for mortality and readmissions within 48 hours fell below the standard set nationally and locally. Evidence-based care bundles were in place but compliance with these demonstrated variable performance.There was evidence of good knowledge relating to consent, mental capacity and Deprivation of Liberty Safeguards (DoLS), although some staff were observed completing tasks without asking for consent and paperwork relating to DoLS was not available within patient notes where applicable.

Staff had good access to information throughout critical care and policies based upon current evidence were in use.Access to seven day services was good throughout critical care.

Evidence-based care and treatment

- The ITU admissions policy and discharge policy were based upon current evidence of best practice as well as recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units and Department of Health guidelines.
- Clinical policies and procedures on the unit were available on the intranet and some printed copies were available for reference on the ward. A lead consultant who was responsible for ensuring policies and procedures on ITU were kept up to date and for uploading new versions onto the intranet so the most recent copy was always available online. Policies we reviewed were seen to have been recently updated and due for review in just under two years. A shared computer drive had been recently set up for staff working in ITU which provided up to date policies and evidence based practice guidance under a range of headings such as governance, major incidents and organ donation. A lead consultant was responsible for ensuring information provided within this area was current and accurate. Despite access to this computer drive only being rolled out the week prior to our inspection, all staff we spoke with knew how to access it and were complimentary about the ease of access for up to date guidance.
- Faculty of Intensive Care Medicine Core Standards for Intensive Care Units advise all patients should be reviewed by an ITU consultant within 12 hours of admission to ITU. Retrospective hospital audit data from July 2015 demonstrated 57% of patients were reviewed within the recommended period, 20% were not reviewed within 12 hours and it was not possible to establish how long a review had taken for the remaining 23% as documentation was unclear regarding when the

patient was first reviewed by a consultant. Staff had been reminded to make this clear in patient notes however this had not been re-audited to assess improvement in this area.

- Ventilator-associated pneumonia (VAP) care bundles were used on ITU in line with current best practice guidance to reduce the risk of infection associated with intubation. We noted compliance with VAP bundles was documented on the daily care chart for all intubated patients and observed staff adhering to the care bundle when looking after them.However data from the North West London Critical Care Network stated 86% compliance with VAP bundles between April and June 2015, which was the second lowest compliance score within the network.
- A central venous catheter (CVC) care bundle was used during the insertion and on going care of CVCs. Data from the North West London Critical Care Network showed service compliance with CVC bundles was 100% between April and June 2015, which was better than many units within the network. We saw CVC bundle documentation had been fully completed with relevant patients during our inspection.
- The Visual Infusion Phlebitis score was used throughout critical care to monitor the wellbeing of patient IV lines, in line with best practice guidance. We saw this documented in most patient notes where appropriate throughout critical care.
- Hospital audits over three data collection periods showed an average of 89% of patients were assessed by a physiotherapist within 24 hours of admission, in line with NICE CG83 guidelines.
- All ITU patients receiving physiotherapy were assessed using the validated Chelsea critical care physical assessment tool. Additionally, evidence-based enhanced recovery programmes were used for certain patient cohorts throughout critical care, for example patients who had undergone a laparotomy. This involved getting patients out of bed and walking as soon as possible after their procedure to limit postoperative complications such as chest infections.

Pain relief

- Patients throughout critical care had their pain assessed at hourly intervals as part of the basic patient observations. Patients who were alert and able to communicate would rate their pain score and unconscious patients were assessed by staff according to their responses to stimuli, such as being turned.
- The assessment of pain for critical care patients was in the process of being reviewed by the critical care 'Nursing Practice Group' at the time of our inspection. Members of the group told us they were reviewing working methods to ensure compliance with best practice guidance.
- Out of hours and at weekends, pain management support was provided throughout the hospital by the anaesthetic registrar on call. Staff told us it could be difficult to get hold of the anaesthetic registrar for patient pain reviews at times due to their theatre commitments,however they usually provided advice over the telephone "which was helpful".
- Patients received analgesia via oral or IV medicines, including patient controlled analgesia (PCA) which could be managed in any of the critical care areas. If epidurals were used for pain relief, patients were cared for within ITU or eHDU where the nurses had special training to use this equipment.

Nutrition and hydration

- There was 0.6WTE band seven specialist dietician allocated to cover ITU, which was compliant with recommendations from the British Dietetic Association. Annual leave and sickness cover was provided by a critical care trained band six member of staff. All patients were assessed on a daily basis from Monday to Friday for parenteral and enteral feeding. Patients within eHDU were also covered by the ITU dietician, however patients within the OIR beds did not have dietician provision funded. Dryden HDU patients were reviewed by the dietician responsible for the rest of the medical ward.
- Patients were able to choose three meals each day from a menu which was provided by catering staff and jugs of water were left at the patient's bedside. Additional snacks and hot drinks were also provided. The menu provided several different options for each meal, including choices suitable for vegetarians, gluten free and 'easy to eat' diets. Halal meat was also available. Catering staff were aware some patients had specific nutritional needs such as gluten free or soft texture and told us they always check with the nurse caring for the patient if they weren't sure.

- Some patients were placed on strict fluid restriction due to their clinical condition. This meant their fluid intake and output had to be closely monitored and recorded to enable an accurate calculation of fluid balance. We saw this in place with patients during our inspection and noted thorough record keeping in relation to this. Staff told us patients on a fluid restriction were carefully monitored by both nursing and medical staff to ensure they did not become "too dry".
- Nursing staff told us nasogastric (NG) tubes were routinely inserted for ventilated patients on admission to ITU. They told us this, alongside nurse led feeding, allowed nutrition to begin as soon as the patient's dietary needs had been assessed.
- Dietetic staff on ITU participated in the International Nutrition Survey 2014 which measured performance against specified criteria. Results from this survey showed it took an average of 48 hours to commence enteral nutrition, which was not in line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. The survey also revealed the required calorie intake was met for 40% of patients receiving enteral feed on ITU.

Patient outcomes

- Since December 2014, ITU contributed data to the 'Intensive Care National Audit and Research Centre' (©ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally. ICNARC data quoted relates specifically to ITU and to the period from December 2014 to June 2015.
- From June 2015 eHDU, OIR and Dryden HDU began collecting data to submit for ICNARC analysis and were awaiting their first summary reports at the time of our inspection.
- ITU also contributed to the North West London Critical Care Network which enabled further outcome and quality benchmarking, specifically against other local critical care units.
- Each critical care unit had an audit programme in place to ensure audits of key performance criteria were completed at appropriate intervals, which was in line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- ICNARC data showed the mortality ratio was 1.15 and mortality on the unit was an average of 25% which were slightly worsethan in other similar units.According to ICNARC data there was a higher frequency of post unit hospital deaths than in other similar units (14.5% in comparison with 10%).
- The ITU discharge policy required all patients to be reviewed by the critical care outreach team upon discharge from ITU however ICNARC statistics demonstrated reviews were not completed for approximately 20% of patients.
- ICNARC data showed approximately 95% of patients discharged from ITU achieved the same or greater level of independence upon discharge from hospital and almost all patients returned to their preadmission residence.
- The number of patients readmitted to ITU within 48 hours of discharge fluctuated,however this was roughly in line with other similar units as shown by ICNARC data. North West London Critical Care Network data for April to June 2015 showed slightly worse performance in this area than on other units within the network.
- ICNARC data showed readmission to ITU after 48 hours affected approximately 5.5% of patients, which was worse than in other similar units nationally.Staff told us it was sometimes necessary to end a patient's ITU stay early in order to "make room" for other patients who needed the service, which was likely to contribute to the rate of readmission.This was supported by ICNARC data which showed approximately 10% of patients were discharged from ITU early.
- Between April 2014 and March 2015, ten patients met the criteria for neurological death testing and all of these eligible patients were referred to thespecialist nurse for organ donation (SNOD). Of these patients, six families consented to organ donation and 24 organs were transplanted into 17 recipients across the country.
- Critical care at Northwick Park Hospital had the joint longest length of stay at a median of 4.6 days between April and June 2015, according to North West London Critical Care Network data. ICNARC data showed the mean length of stay was 6.8 days which was longer than in other comparable units nationally.

Competent staff

Nursing Staff:

- New nurses across critical care underwent a period of supernumerary practice, during which basic competencies were signed off before the staff member

was able to work independently. We saw evidence of induction documentation and staff who had recently started told us they were "eased in" to the unit in a supportive and educational manner.

- Competency documents were in place for band six and band seven nurses. Staff told us their progress and performance was measured against these documents and they were encouraged to gain confidence with the required tasks before having the competency signed off.
- Agency nurses were inducted onto the relevant unit on their first shift and we saw evidence of induction and competency document completion with these staff members. Senior staff told us they endeavoured to allocate agency staff patients next to senior permanent staff members so support was immediately available.
- There was a dedicated practice development nurse (PDN) who was responsible for training staff in a variety of topics, including in the use of specific medical devices. We saw training records demonstrating teaching sessions took place and staff received 'refresher' training when needed, such as for haemofiltration and cardiac output monitoring. A business case for an additional PDN had been approved and senior staff told us they were starting to recruit into this post.
- Nursing staff across critical care told us they were supported with opportunities for further development, such as attending a critical care nursing or mentoring course. Several courses,such as critical care nursing,were funded by the trust and study leave was provided. Band six nurses also had the opportunity to shadow the nurse in charge to gain managerial experience.
- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post registration award in critical care nursing. Additional critical care nursing awards had been achieved by 67% of nursing staff in ITU and all band six staff within Dryden HDU. Of the staff who cared for patients in eHDU or OIR, 21% had critical care nursing awards.
- Nursing students throughout critical care told us they worked almost every shift with one of their mentors and had been very well supported with their development. We observed senior nursing staff actively seeking out nursing students for observational learning opportunities, such as when a patient was a having a tracheostomy inserted.
- Staff told us they received regular one to one meetings with their appraiser and had formal appraisals on a yearly basis. An average of 82.5% of critical care staff had an up to date appraisal and senior staff told us plans were in place to complete the remaining appraisals by December 2015.

Medical Staff:

- All new staff attended the generic trust induction and received additional mandatory training, such as basic life support. New medical staff were inducted onto the relevant unit by an experienced colleague, with explanations of policies, procedures and timetabling, such as when MDT meetings occurred.
- ITU consultants had developed a peer support system with the on duty consultant covering ITU at Central Middlesex Hospital. They met twice per week and during the weekly MDT meeting to discuss patient management and any concerns or queries which had arisen. Staff told us the two units worked closely together and there was a supportive relationship which worked "both ways".
- All registrars responsible for critical care areas within the hospital were experienced specialist trainee doctors and had intermediate life support training. The registrars responsible for ITU and eHDU overnight also had advanced airway skills.
- There was weekly training for junior doctors held within ITU, theatres and medicine. Staff provided positive feedback about their experiences of teaching and told us there was also a large amount of teaching completed at the patient bedside. We observed a junior doctor training session and found a positive learning environment for the trainees.

Multidisciplinary working

- Daily ward rounds on ITU were attended by the medical team, nursing staff and pharmacists. Physiotherapists and dieticians were present for the ward round on two or three days a week, depending upon other responsibilities. Ward round on eHDU involved the medical team and nurse in charge only. These ward round arrangements were not compliant with the recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. A daily MDT handover took place on Dryden HDU with attendance from pharmacy and therapists.

Critical care

- There was a weekly multidisciplinary meeting held for ITU patients which involved the medical team, senior nurse, ward therapists, radiologists, microbiologists, pharmacists and dieticians. The meeting was attended by staff from Central Middlesex Hospital via video link and their ITU patients were also discussed. All aspects of patient care were reviewed and staff had the opportunity to raise any questions or concerns about patient progress or care plans. There were no other formal multidisciplinary meetings held for patients in other areas of critical care and staff told us these were not needed due to fast patient turnover.
- On ITU and Dryden HDU, doctors worked closely with nursing and physiotherapy staff to establish and implement ventilator weaning programmes (when patients' reliability on breathing machines is reducing and they are able to do more breathing on their own).
- Therapists liaised with nursing staff to agree therapy plans in line with other activities scheduled for each patient during the day, such as scans or ventilator weaning times. Staff told us they worked well together and would always try to be flexible to optimise the patient's progress.
- Staff within the ITU follow up clinics liaised with external services to ensure patients who had been discharged from hospital could access the necessary services once home; for example,a follow up nurse facilitated a referral to a sexual dysfunction clinic via a patient's GP following a discussion with the patient at their follow up clinic.
- We observed liaison across the critical care network to locate a suitable ITU bed for a patient being admitted from the accident and emergency department. We were told there were no ITU beds were available within the trust and the patient would need transferring out of area to received appropriate care. We noted there were ITU beds available in Ealing Hospital's critical care unit. We raised this with staff afterwards and they told us there had been no direct communication between Northwick Park ITU and the critical care unit at Ealing and therefore the bed availability was unknown.
- A Specialist Nurse for Organ Donation (SNOD) was available on site via a bleep or face to face referral system. Staff described a proactive approach to referrals and the SNOD told us referrals were received at the "right time" so potential donors still had viable organs for transplantation.

Seven-day services

- The critical care outreach team was available 24 hours per day, seven days per week to provide support on the wards caring for deteriorating patients and following up patients recently discharged from critical care.
- Imaging services were available with a full service from 9am to 6pm Monday to Friday and an emergency service available outside of these times, including at weekends. Referrals for imaging were made via an electronic referral form and staff told us critical care patients were prioritised for imaging investigations. Image reviews were completed by a radiologist Monday to Friday and by an on call registrar out of hours.
- Physiotherapy was provided across critical care by the ITU, surgery and medical teams. Therapists worked from Monday to Friday 8:30am to 4:45pm. Outside of these hours, an on call therapist was available for emergency respiratory treatments and was available via a bleep, with a 45 minute response time. A full respiratory and rehabilitation service was also available for appropriate patients on Saturdays and Sundays.
- Speech and language therapy (SALT) was available from Monday to Friday on a bleep referral basis. Staff told us nursing staff could complete some basic swallowing assessments but the majority of patients with swallowing difficulties were seen by SALT in addition to this.
- A SNOD was available on site between 8am to 5pm Monday to Friday. Outside of these times, access to SNOD support was available via the regional on call system where the duty SNOD was responsible for covering all hospitals within the catchment area.

Access to information

- New medical folders were set up for patients on admission to critical care if they had come via the accident and emergency department or been transferred in from another unit. The patient's hospital medical notes would then be requested from medical records and staff told us they were normally received on the unit within 24 hours. Patients who had deteriorated on the wards or been admitted from theatre were transferred to the unit with their full medical notes. Staff told us it was rare to have difficulty accessing the patient's notes quickly.
- Specific transfer document forms were used when patients were moved between or out of critical care.

These forms provided the receiving team with a brief summary of the key points relating to the patients' care. Staff on the receiving wards told us these forms were a useful "quick reference" guide when they received the patient and augmented the verbal handover which was also completed.

- Separate paper records were kept for patients visiting the ITU follow up clinic and no access to the patient's ITU admission notes werein place. Staff told us the follow up clinic used to be documented in the main medical notes,however this became complicated and so it was decided to keep separate records.
- Copies of documents outlining various nursing procedures were kept within each patent bed space. Updating these folders was the responsibility of a designated link nurse and all folders we reviewed contained up to date information. Staff told us having paper copies of these procedures was useful as it meant they could access the information without having to leave the patient bedside

Consent, Mental Capacity Act and DoLS

- Staff were able to correctly explain how consent should be obtained from patients prior to interventions and 'best interests' were needed when the patient was unable to consent, for example ifan unconscious patients required a change of position, this was completed with the patient's best interests in mind. We observed staff asking forthe patient'spermission prior to taking blood and giving them medicines. However,during ward rounds,we observed some members of the team did not always ask for patient consent prior to completing part of their assessment, for example before listening to the patient's chest.
- Most senior staff understood the involvement of patients' relatives in providing consent, in that they could be used to gauge what the patient would have wanted but could not actually consent to a procedure on the patient's behalf. They told us 'best interests' decisions would be used in this case.
- Staff described circumstances when Mental Capacity Act (MCA) principle were applied and knew patients must be presumed as having capacity to make decisions until proven otherwise. We observed assessments of capacity documented in patient notes where appropriate and use of the psychiatric liaison team for guidance with complex patients.
- A Deprivation of Liberty Safeguards (DoLS) policy was in place within the trust and made specific reference to patients receiving intensive care, although the policy stated this was undergoing a specific review. In accordance with guidance form the Department of health, certain patients within ITU would not be considered as deprived of their liberties; for example patients who consented to admission to intensive care as well as the restrictions associated with this type of admission.
- We reviewed the notes of a patient who was being prevented from leaving the ward and noted a DoLS application was recorded as approved, although there was no evidence of this in the patient's notes. We raised this issue with the bedside nurse and Matron who told us a copy of the completed DoLS should always be stored in the bedside notes. In response to our query, a digital copy of the approved DoLS application was printed and placed in the bedside notes.

Are critical care services caring?

Good

The care provided throughout critical care was good. Results from the Friends and Family Test showed almost all patients would recommend the service. Completion ofthe Short Observational Framework for Inspection (SOFI) demonstrated a high proportion of positive interactions between staff and patients. Good emotional support was provided by ward staff and there was access to other support services such as chaplaincy on the units.

Feedback from patients and relatives was positive; staff were described as "friendly" and patients told us staff took the time to get to know them as individuals. Patients were addressed by their preferred name and told us staff were "sympathetic" and "reassuring" when completing interventions such as intimate care.

Patients and their families were involved in decisions about their care, such as during ward round discussions. Staff allowed patients and visitors time to ask questions and provided clear explanations. Privacy and dignity was maintained by most staff although we noted some staff entering bed spaces which had closed curtains without asking permission first.

Critical care

Compassionate care

- The Friends and Family Test (FFT) achieved a response rate of 47% on ITU and 94% in eHDU and theatres recovery (joint result) between April and July 2015, with 98% of ITU and 100% of eHDU/recovery respondents saying they would recommend the units.Additional relative feedback cards and a collection box were located within the relatives waiting area to obtain further comments from patients' visitors.
- All levels of staff across critical care spoke kindly to patients while working and patients were complimentary about their interactions with staff. Patients described staff as "friendly and caring" and told us they took time to get to know patients and their families. One patient told us "staff don't realise how good they are".
- Staff spokewithpatients in a considerate and respectful manner, addressing patients by their preferred name. Patients told us staff asked them what they liked to be called and ensured this was handed over to their colleagues. One patient told us being called by their nickname made them feel like they were "at home" and "among friends".
- Staff interacted quietly and gently with unconscious patients. They introduced themselves and explained interventions to the patient prior to beginning so the patient was not startled.
- We observed staff ensure patient call bells were left within reach for conscious patients and these were answered quickly by staff when required.However one patient told us the call bell did not work and so was unable to attract attention overnight. This had been reported to ward staff but was not fixed during the patient's admission.
- Patients told us their privacy and dignity was maintained by staff who ensured they were suitably covered with a hospital gown and a bed sheet at all times. In patient bay areas, large white screens were used to partition the ward to help maintain patient privacy and dignity.
- We observed most staff ensure bed space curtains were fully closed when patients were receiving intimate care or having a procedure. Red warning signs were placed on bed space curtains and were intended to help preserve patient privacy and dignity by limiting staff entry.However,we noted on several occasions these signs were ignored by staff who entered the bed space without requesting permission.
- Patients and relatives told us staff regularly checked patient comfort and offered assistance with repositioning or additional pain relief if needed. Patients told us their pain was well managed and pain relief was provided quickly when required.
- There were thank you cards from previous patients and their relatives on display throughout critical care, all praising the kindness of staff. Numerous cards praised the "dedication" and "commitment to care" which had been displayed by various members of the team and several cards described the staff as "amazing".
- One patient praised the caring attitude of the eHDU staff and told us they offered to assist with two washes per day and encouraged twice per day teeth cleaning, which had not occurred during the patient's previous hospital admissions.
- We observed a patient being discharged from ITU to the wards and many nurses came to wish the patient well before the transfer.
- Our short observation framework for inspection (SOFI) demonstrated a high proportion of positive interactions between staff and patients. However we noted some occasions where staff spoke over patients and failed to introduce themselves, particularly within the eHDU area.
- We observed a member of staff supervising apatient who required additional attentionand using confrontational body language, such as holding both hands up very close to the patient's face, which was not appropriate.

Understanding and involvement of patients and those close to them

- Patients told us medical staff provided clear and thorough explanations, with opportunities to ask questions about their plan of care. Patients told us theywere involved in decisions about their care and the team checked they were happy with how their treatment was progressing.
- Patients were encouraged and supported to make decisions about their own wellbeing, such as when to wash and which activities to engage in, for example with therapy staff.

- Relatives were able to speak to the medical team throughout the day. They told us they were kept informed and could ask questions about their loved one's care whenever they wanted. They told us they were involved in decision making and could be involved in their relative's care if they wanted to be.
- Relatives told us they were encouraged to be involved in activities with their loved one, for example assisting with physiotherapy stretching and reading newspaper articles to unconscious patients. They told us this helped make them feel "useful" and like they were helping the patient to get better.
- We observed medical ward rounds across critical care which included discussion with patients where possible and their relatives. Members of the medical team were introduced, a brief discussion about the patient's progress was held and the expected plan of care was decided. The medical teams checked the patients were happy with their recommendations.
- Meetings for relatives with the medical team were held on an "as required" basis and could be requested by either party to discuss concerns or the ongoing care plan. Relatives spoke positively of these meetings and told us the process helped their understanding of the patient's progress.
- A Specialist Nurse for Organ Donation (SNOD) was based on ITU and worked closely with the critical care team to identify potential organ donors. The SNOD was introduced to relatives of potential organ donors who had been told their loved one was dying and provided information regarding organ donation. Staff told us the SNOD would remain involved in supporting relatives of these patients whether they decided to allow organ donation or not.
- At the entrance to ITU, a poster board displayed photographs of ward staff alongside their name and job title so patients and their relatives knew who staff on the wards were.

Emotional support

- Staff told us they provided emotional support to patients as part of their day to day work. Patients described staff as "reassuring" and "sympathetic" when completing procedures such as putting in IV lines. We observed staff approaching patients in a sensitive manner and providing a calming influence when patients were anxious.
- Patients were able to speak to their relatives on the ward telephone where they were not able to use their own portable devices and staff supported them with this by bringing the portable phone to the patient's bed space.
- A chaplaincy service was available 24 hours per day, seven days per week. The team offered spiritual or religious support to patients, relatives and staff members alike.
- Staff from the follow up clinic told us they were in the process of setting up an annual memorial service for relatives of patients who died on ITU. Staff told us a venue was planned and chaplaincy staff had been booked to lead the sessions, however the sessions were "not set in stone" at the time of our inspection.
- The SNOD provided support for bereaved families where appropriate and assisted them in obtaining certain keepsakes from their loved ones such as a lock of hair and hand prints.
- Staff across critical care were aware of external support organisations which could be accessed by patients and relatives if required. One staff member gave an example of signposting a relative to a charitable counselling service to help them come to terms with the loss of their loved one.

Are critical care services responsive?

Requires improvement

The responsiveness of critical care required improvement. Bed occupancy across critical care was consistently above the national average and the service was identified as having the largest shortfall of beds within the North West London Critical Care Network. Capacity issues had affected elective surgical activity but no plans were in place to mitigate the capacity issues at the time of our inspection. There was a high proportion of patents discharged out of hours and significantly more non-clinical transfers than in other similar units nationally and across the local network.

A flexible service was planned and provided within the capacity constraints and patients with the most urgent needs were prioritised. Just over half of ITU patients were admitted to the unit within the recommended four hour timeframe and were reviewed by a consultant within 12 hours of their admission to critical care. Patients ventilated

for four days or more and all critical care maternity patients had access to a follow up clinic. There wereappropriatefacilities for relatives within critical care on most units and we saw proactive responsesto negative feedback from patients and their visitors.

Service planning and delivery to meet the needs of local people

- ITU served a combination of elective postoperative patients, emergency postoperative patients and medical patients requiring critical care. The ITU admissions policy supports the admission of patients with a reversible, acute condition who are appropriate for advanced medical interventions and who would be at risk if they remained in a general ward area. Staff told us service planning could be difficult due to the variable number of emergency admissions which took place and needed to be managed alongside the booked surgical admissions.
- eHDU staff told us there was a formal admissions policy for the unit but this was often not adhered to. Staff told us the eHDU admissions policy was to care for postoperative patients for up to 48 hours post procedure at which point the patient should then be transferred to the surgical wards for on-going care. Patients who were likely to require critical care involvement for more than 48 hours should be booked into an ITU bed instead. Staff described how, in practice, they received a variety of patients including medical patients and complex postoperative patients who, in their opinion, would be better served on other units. Staff told us the eHDU area was “frequently” used as a regular surgical HDU rather than as the short stay unit it was intended as.During our inspection there was a patient on the unit for their 20th day.
- Admissions to Dryden HDU could be accepted by the medical consultant or registrar responsible for the unit. The unit admitted medical patients who required one or two organ support such as patients requiring non-invasive respiratory or blood pressure support. Most patients (60%) were admitted via the accident and emergency department and 65% of patients were respiratory patients.
- Staff explained it was necessary to “juggle” the patient caseload between the critical care units at Northwick Park Hospital and Central Middlesex Hospital to meet the needs of the patient population. This meant prioritising the most unwell patients, ensuring they were cared for within ITU and not transferred, and stepping down or facilitating patient transfers to other units where appropriate. Staff were aware of the risks involved in this type service provision but explained it was the only effective way of ensuring access to those who required critical care.
- Access to an ITU follow up clinic was available to patients who were ventilated for four days or more and to all maternity ITU patients. Clinics were held on alternate Fridays and were led by senior ITU nurses, with support from a maternity sister and an obstetrician for maternity patients. Initial contact was made by one of the follow up nurses one month post hospital discharge and follow up appointments were made at three month, six months and nine month intervals. Patients had the opportunity to discuss any ongoing medical problems, reflect upon their admission to ITU and also to visit the unit if they wanted to.
- Visiting times varied across the critical care service and staff told us times could be flexible according to the needs of individual patients and their relatives. Visiting times for ITU were 11am-1pm and 2:30-8:30pm. On eHDU visitors were scheduled between 2-4pm and 6-8pm.
- There was a large visitors’ waiting area at the main ward entrance to ITU which had seating for 12 people and access to a visitors’ bathroom. Information boards displayed key information about what to expect on the unit such as the monitoring systems, ventilators, doctor involvement and other items which might be found in the patient bed space. Hot and cold drink making facilities were available, along with a microwave and fridge. An orange buzzer and intercom system was located within the waiting area which enabled waiting relatives to communicate with ward staff to find out if patients were ready for visitors. A separate interview room was available opposite the main relative’s waiting area in ITU which was used for confidential discussions with families.
- A visitors’ waiting room was available within Dryden Ward which was also used as a quiet room for confidential discussions if required. Facilities provided included a visitors’ bathroom and hot drink making facilities. Information leaflets were available, such as about MRSA and hand hygiene.

- There was a waiting area available for visitors to eHDU and the OIR which was shared with the recovery department. This was a small room with seating for eight people and little natural light or other facilities.
- There were limited facilities for relatives to stay over close by to the unit. This service was reserved for the relatives of the most unwell patients and those who had no nearby accommodation.

Meeting people's individual needs

- Staff on critical care made use of chaperones during procedures and care tasks for patients where this was requested. Posters advertising this were on display on information boards and were shown in 11 different languages.
- Support for patients with psychiatric conditions was available via the psychiatry liaison team who covered patients with mental health needs across the hospital. We saw evidence this team was contacted and used to support the care of relevant patients within the critical care setting.
- Staff were unclear what additional support was available in the hospital to assist them in caring for patients with a learning disability. Staff told us they would use the expertise of the patient's parents or carer to "get tips" on how best to care for that particular individual.
- Staff told us a "Patient Care and Religious Beliefs" folder was available on the ward which outlined the needs of patients from a variety of religions. There was specific information relating to dietary requirements, prayer and end of life care.
- Televisions and radios were available for patients in some areas of critical care on a first come, first served basis. Staff took care to ensure the volume of this equipment was kept low and patients were assisted to use headphones if required.
- Information was displayed within relative waiting areas in a variety of languages and posters advertised availability of translation services. Staff told us translators were frequently used within critical care, most commonly on a face to face basis but sometimes via telephone.

Access and flow

- NHS England statistics demonstrated critical care bed occupancy was consistently above the national average between October 2014 and September 2015. This was not in line with the Royal of Anaesthetists recommendation of 70% critical care occupancy. The recommended occupancy rates allow for units to be able to take in more patients should there be an emergency. If a unit is at a higher occupancy,it is unable to respond to emergency admissions and may find they are required to step-down patients too early or transfer patients to other hospitals out of their locality.
- The North West London Critical Care Network data for April to June 2015 demonstrated critical care at Northwick Park Hospital had the largest shortfall in capacity within the network. Shortfalls in the capacity of critical care had been frequently identified by senior staff and was recorded on the departmental risk register but no plans to address this issue had been identified at the time of our inspection.
- Where patients such as complex elective surgical patients were expected to be admitted to critical care, a bed would be pre-emptivelybooked on ITU or eHDU for this purpose. This bed booking would be reviewed with senior critical care staff on the morning of the patient's surgery to ensure a bed was available. If a bed was not immediately available, staff would review the needs of patients on the unit and transfer patients or step down care as appropriate to try and ensure the elective surgery could go ahead. Between January and August 201517 elective procedures had been cancelled due to lack of availability of critical care beds, which was a small proportion of all surgical cancellations.
- Emergency patients accessed critical care either by direct medical referral or commonly via the critical care outreach team. After being reviewed, the patient's care would either be supported at ward level by the outreach staff or escalated to a critical care unit if required.
- Faculty of Intensive Care Medicine Core Standards for Intensive Care Units advise patients should be transferred to ITU within four hours of the decision to admit. Hospital audit data from July 2015 indicated 57% of patients were admitted within the four hour time frame, 11% were admitted after four hours and the time for the remaining 32% of patients was unclear.
- Faculty of Intensive Care Medicine Core Standards for Intensive Care Units advise all patients should be reviewed by an ITU consultant within 12 hours of admission to ITU. Retrospective hospital audit data from July 2015 demonstrated 57% of patients were reviewed

within the recommended period, 20% were not reviewed within 12 hours and it was not possible to establish how long a review had taken for the remaining 23%

- Information from ICNARC indicated fewer patients experienced delayed discharges from ITU than in other similar units.
- Patients discharged from critical care 'out of hours' between 10pm and 7am are nationally associated with worse outcomes and ICNARC data from December 2014 to June 2015 demonstrated a fluctuating proportion of patients (8-14%) were affected by this. Performance in this area was slightly worse than in other similar units across the country. Data from the North West London Critical Care Network for April to June 2015 showed the unit had the highest proportion of out of hours discharges within the network. Senior staff told us out of hours discharges were not recorded as incidents which was not in line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- ICNARC data from December 2014 to June 2015 demonstrated there were consistently more non-clinical transfers from ITU than in other comparable units. Between April and June 2015, there were almost ten times as many non-clinical transfers from ITU than the average. ITU staff attributed this to the limited critical care capacity at the hospital and told us low risk patients were usually transferred to the "lifeboat" critical care at Central Middlesex Hospital when needed so more unwell patients could be cared for within ITU at Northwick Park Hospital.

Learning from complaints and concerns

- Throughout critical care, there were many posters advertising the services of the Patient Advice and Liaison Service (PALS) who assisted patients and their relatives with making formal complaints. The posters identified where PALS were located within the hospital and how to contact the service.
- Staff told us there were very few complaints made about critical care and most issues were managed at ward level by senior staff or the matron. Informal complaints were not usually recorded. Between October 2014 and November 2015 there had been three formal complaints about ITU, three complaints about eHDU and one complaint about Dryden HDU. We saw evidence demonstrating there was a delayed response to complaints made throughout critical care.
- We saw examples where staff had responded to negative patient feedback, such as when a patient commented about the squeaky unit door this was passed onto the estates team immediately to be addressed.

Are critical care services well-led?

Requires improvement

The leadership within critical care required improvement. The shortcomings in critical care capacity were widely acknowledged throughout the service and attempts had been made tohighlight this issue to the trust board however there had been no further development after this.The on-going vision for critical care was to sustain the current service and there were no additional strategies in place for development. Additionally the lack of critical care oversight of eHDU had not been identified as a risk by the leadership team and as a result there were no plans to address this.

Governance processes were in place across the service but there was little cross site learning other than between ITU and critical care at Central Middlesex Hospital, and limited learning from other specialities within the hospital. We noted an obvious desire across critical care to improvement quality of care provided and some innovation. A relationship with Ealing Hospital critical care was identified as an area for development but processes to achieve this were not in place.

The clinical leadershipand management were aware of the difficulties faced by the service.Most were recorded on the risk register. There was an open culture on the unit which encouraged honesty and constructive challenge.

Vision and strategy for this service

- The insufficient critical care capacity and issues associated with this were widely acknowledged throughout critical care. The service was described as "struggling to keep heads above water" by a senior member of staff who explained the on-going vision is "just to keep going" while these issues remain in place.

- Senior staff told us quality and safety remained at the forefront of their clinical practice however it was difficult to formulate a vision for development beyond improving the capacity issues as there was no available time for staff to innovate or drive the service forward within the current service constraints. Some staff described linked working with critical care at Ealing Hospital as something to work towards however neither department had instigated processes to begin this, attributing this to resistance from their opposite number.
- The clinical lead and general manager for ITU had completed work on a report identifying the anticipated number of critical care beds required at the hospital which was calculated as 42. This took into account the number of patients currently transferred to Central Middlesex Hospital for critical care, current unmet HDU needs, an anticipated increase in elective surgical activity and in emergency admissions, and the ability to function at 70% capacity as per the Royal College of Anaesthetists guidance. This report and supporting ICNARC data (such as the number of non-clinical transfers out) had been provided to board level managers however no strategies were in place to address the current short fall of critical care beds within the hospital. Senior critical care staff described the feedback from the trust senior management team as a "head in the sand response".
- A new senior member of staff had been recruited to the trust senior management team and senior critical care staff described confidence in this person to facilitate change within the service. This was due to views expressed regarding the quality of the critical care service within the hospital and the fact this reflected the views of the service management.
- Ward level staff were unsure of a specific vision or strategy for the service although were aware the flow of patients "didn't work" because more critical care beds were needed. They described a focus on quality and safety whilst working with the facilities available.

Governance, risk management and quality measurement

- The 'Critical Care Incident Review Group' met on a monthly basis to discuss incidents which had occurred on ITU at Northwick Park Hospital and Central Middlesex Hospital and any learning points which could be carried forward. There was no involvement from staff responsible for other areas of critical care within Northwick Park Hospital or from Ealing Hospital.
- Clinical governance information sessions were held by senior critical care staff three times per year with topics such as safety, quality measures and morbidity and mortality reviews. Ward staff told us they were actively encouraged to attend these meeting by senior staff and the meetings were useful.
- Alert posters entitled "Watch Out" were created and displayed in critical care areas highlighting key issues such as patient allergies and pressure sores. Senior staff told us themes were selected according to the occurrence of incidents and performance reflected by quality dashboard indicators. We observed these posters in place throughout critical care and staff spoke positively about the role the posters played in reinforcing quality care.
- Senior staff described attempts at branching out their clinical governance activities to share learning with other areas, such as surgery, as being met with resistance from senior trust staff. Senior critical care staffsaid this was a wasted learning opportunity which could improve safety across all areas of the trust.
- Critical care morbidity and mortality meetings were held alongside the weekly MDT meeting. Minutes from these meetings demonstrated discussions relating to patient deaths on the unit, including whether any critical care involvement could have been improved.
- The departmental risk register was maintained by senior ward staff and service management. The issues identified on the risk register largely reflected our inspection findings.
- Capacity issues were recorded on the critical care risk register and senior staff told us they had recommended this was extended to the trust-wide risk register. Staff told us this had been suggestion had been turned down by trust management and described this as an example of the "disconnection" between the senior management team and the critical care service. We checked this information on the trust risk register and found no reference to lack of capacity in critical care.
- The lack of appropriate medical cover in eHDU had not been identified as a risk by the critical care leadership team and consequently there were no plans in place to address this.

- A business case had been submitted to create a post for an audit nurse to be responsible for submitting data to ICNARC for eHDU and Dryden HDU. This would allow performance data to be analysed for these areas of critical care and also benchmarked against other similar units. Senior critical care staff said this was essential for the development of a quality critical care service. At the time of our inspection, the business case was being considered by senior management within the trust.

Leadership of service

- Clinical leadership was provided by the clinical lead for ITU and by clinical leads for medicine (Dryden HDU) or theatres (eHDU and OIR). Clinical leads for Dryden HDU, eHDU and OIR did not have critical care backgrounds. The clinical leads worked closely with clinicians on each unit to address governance and quality issues within the service. Consultants across critical caresaid they had a good relationship with the service leadership.
- Junior doctors were aware of the leadership structure across critical care and knew who to speak to about their concerns. They told us they were comfortable approaching their clinical leads with any issues,however they were unsure what outcome would be achieved at higher levels of management.
- Matrons for ITU and the OIR/eHDU worked closely together and provided cover for each other during annual leave and sickness. Staff told us this system worked well and they were happy to approach either matron with any issues or concerns. These matrons met with the divisional lead on a weekly basis to discuss any issues or concerns within the service.
- The matron responsible for Dryden HDU was “very separate” from the other critical care matrons due to working under a different division within the hospital and there was minimal crossover of leadership, learning opportunities and quality measures. Staff on Dryden HDU told us they would prefer leadership for the unit to fall under critical care.
- Shift leaders meetings were held every eight weeks alongside staff from critical care at Central Middlesex Hospital. Within these meetings, trust-wide critical care issues such as staff rotations, bed management and service updates were discussed, however no representative from Ealing Hospital critical care was present.
- Senior staff across critical careindicated there was poor understanding of the needs of critical care within the hospital management and told us, in their opinion,there was little support for the service. They believed the service was undervalued by the senior management team and there was little acknowledgement of the difficulties faced by the service as a whole.

Culture within the service

- Ward staff told us theyperceivedthey werevalued by senior staff within the service and like they were an important member of the team. Staff told us people were acknowledged for their individual skills and knowledge which were put to use during teaching sessions and support for less experienced staff.
- Staff valued their colleagues in critical care at Central Middlesex Hospital and described their service as being a “lifeboat” to the overflowing critical care at Northwick Park Hospital. Itwas widely acknowledged across critical care, and particularly in ITU, the service would not cope without the additional support provided by Central Middlesex Hospital.
- We noted staff working within critical care were concerned with the welfare of their colleagues; for example we observed a member of staff who was unwell being encouraged to take a break from work to have a drink and “take it easy for a few minutes”.
- We observed a friendly and open culture throughout critical care, where staff were able to ask questions and admit to gaps in their knowledge to seek support and guidance. Staff told us the culture on the units encouraged constructive challenge to improve patient care and staff told us they were confident questioning the practice of their colleagues and seniors to benefit patients.
- Staff sickness rates varied between 2.9-5% throughout critical care which is in line with sickness in other areas of the trust.

Public and staff engagement

- Patient focus groups were used to allow the public to share their experiences and shape certain aspects of the critical care service. For example the critical care follow up clinic assumed its current format based upon feedback from previous patients and their relatives.
- Feedback from patients and their relatives was obtained via feedback cards which could highlight suggestions for future improvement or praise anything the unit was doing particularly well.

- Staff were aware of whistleblowing procedures and the importance of raising concerns formally if appropriate.
- Regular unit meetings were held on all critical care units for ward management to provide any relevant information to staff, for example updates regarding cost saving initiatives and any changes to relevant policies or procedures.
- ITU nursing staff received feedback regarding results from ICNARC reports. Senior staff told us this meant ward staff could understand the performance on the unit and were encouraged to make suggestions for areas of improvement.
- Specific staff achievements, such as completing courses or receiving awards, were acknowledged in the trust-wide newsletter and also during ward handovers with the staff member present. Staff told us theyperceived thattheir achievements were recognised by other staff within the hospital.

Innovation, improvement and sustainability

- A smartphone application designed to assist junior doctors with prescribing on critical care was in the process of being developed at the time of our inspection. Senior staff told us they believed providing information for staff in an accessible and up to date manner would assist engagement with best practice prescribing.
- Support from trust management had been obtained to develop the critical care outreach service into a full 24 hour per day, seven day per week service. Additional funding had been agreed to further improving the staffing establishment to ensure sustainability of this service.
- A data review group comprising of senior nurses and ITU consultants had recently been set up on ITU to analyse ICNARC reports and determine actions to address areas of suboptimal performance. Staff described the rate of out of hours discharges as one area they sought to improve upon. They had recently implemented a new policy regarding this which meant out of hours transfers would only occur if there were no empty beds on the unit and a patient elsewhere in the hospital required urgent transfer to ITU.
- The Nursing Practice Group (NPG) met regularly to ensure the critical care units were compliant with best practice guidance, draft new policies and identify areas for development within the service. Staff told us the drug charts had recently been updated in response to discussions by the NPG.
- Critical care was aiming to be an “agency-free” service which meant no usage of agency staff to cover nursing shifts. This was part of a cost improvement programme and was targeted at addressing previous high spending on agency staff. To ensure agency staff were not used, there had been a recruitment drive to fill substantive posts and an increase in bank staff, most of which were substantive staff covering extra shifts. Senior staff told us this was not only a cost saving exercise but it also improved quality and safety due to improved consistency of staff.

Maternity and gynaecology

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

Information about the service

London North West Healthcare NHS Trustoffers the full range of maternity and family planning services. Between January to December 2014 the trust delivered 4,590 babies. Almost all deliveries within the trust take place at Northwick Park Hospital. Antenatal clinics are held at Northwick Park Hospital, Central Middlesex Hospital and Ealing Hospital as well as local children's centres.

There are a number of specialist midwives in post to support women such as those with diabetes, infant feeding midwife and screening midwife. There are breast feeding clinics held to provide advice and support to women.

Northwick Park Hospital has a midwife-led birthing unit, which is designed for women assessed as having a 'low risk' pregnancy. It has six birthing rooms, two of which are fitted with birthing pools. The main delivery suite has 11 delivery rooms, four high dependency beds, four recovery beds, one triage assessment room, four observation trolleys and two dedicated obstetric operating theatres. There is also a birthing pool fitted in one of the rooms. There is a community midwifery service and a home birth service.

Outpatient antenatal, ultrasound, postnatal care and gynaecology servicesare provided at Ealing hospital since July 2015.

During our inspection we spoke with 20 patients and 30 staff, these included midwives, nurses, housekeeping staff, senior managers and doctors. We observed a shift handover. We reviewed eight patient health care records.

We looked at equipment throughout the service, which included resuscitation equipment and fetal scanning machines. Before during and after the inspection we reviewed the trusts performance information.

Maternity and gynaecology

Summary of findings

We found concerns regarding the safety arrangements in the maternity services.These related to midwife shortages, not having safety thermometers on display in all areas and some staff reporting that they did not get feedback after reporting incidents.

Staff shared concerns with us that the Day Assessment Unit (DAU) was too hot and that chairs used for patients having CTGs were difficult to manoeuvre and recline. We noticed that the reclining mechanism on these chairs was broken; therefore staff had to manually manoeuvre the chairs using excessive force. This was hazardous to both patients and staff. We found the DAU very hot especially in the office area and patient waiting room.

The records we reviewed showed venous thromboembolism (VTE) assessments were carried out and maternity early warning score (EWS) assessments were being completed. Gynaecology was also completing EWS. There were up-to-date evidence-based guidelines in place, however we were not able to find evidence that 'Fresh eye' checks were being recorded every hour for women during labour.

We did observe good practice in terms of effective multidisciplinary team working, multidisciplinary handover on delivery suite and that staff had the right skills, qualifications and knowledge for their role.

Consultants were resident in the labour ward 24 hours on four days a week and via on-call rotas from home out of hours three nights a week.

Some womenexperiencing pregnancy loss were being cared for in a room without sound-proofing. This meant that women in the room could hear the sounds of babies crying and this could cause distress. However, people told us they were consistently treated with dignity, kindness, and respect throughout the services.

We requested the current percentages of women seen in the labour ward within 30 minutes by a midwife, and the percentage seen by a consultant within 60 minutes, to determine timeliness of assessment. This information however was not being recorded.

Most of the people using the service told us that did not know who to make a complaint. Between October 2014 to September 2015 the service received 64 complaints. 13 of these were still open and being investigated at the time of the inspection. Some complaints had been open for over two months.

The Trust had a clear vision and strategy however the staff we spoke with did not demonstrate awareness or understanding of it. The trust vision and strategy was not visible throughout the wards and corridors. We saw the services' business plan for 2015 – 2016. It did not include the vision of the service.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

We found that the current safety arrangements in maternity and requires improvement due to the issues we evidenced in the maternity service. NHS Safety Thermometer was not displayed in public areas throughout the service, with the exception of the postnatal wardand we were not given the results.

We found that 'fresh eye' checks were not always being carried out for women in labour. This is when another midwife reviews the heart rate of the foetus during labour.

Staff fromacross the service and from various professions at Northwick Park Hospital, told us that staffing levels was a concern. Staff told us that the lack of midwives meant that those on duty worked without getting a break during their shift. They reported that this was impacting on the safety.

Some staff told us that they did not always get feedback after reporting incidents. We did see the 'risk news' newsletter in the staffroom at Northwick Park Hospital. However, staff at Ealing Hospitalinformed us they did not get the newsletter.

Staff shared concerns with us that the Day Assessment Unit (DAU) at Northwick Park Hospital was too hot and that chairs used for patients having CTGs were difficult to manoeuvre and recline. We noticed that the reclining mechanism on these chairs was broken; therefore staff had to manually manoeuvre the chairs using excessive force. This was hazardous to both patients and staff

Compliance with mandatory training was below the trusts target level in a number of areas. Overall, 69% of staff at Northwick Park and 44% at Ealing Hospital had completedlevel 3 safeguarding adults and children training.

At Ealing Hospital we found out of date drugs in the medicines fridge. Audits were also not being carried out to benchmark the service.

Incidents

- Both maternity and gynaecological services promoted the reporting and learning from incidents. All staff that we interviewed had a clear understanding of the reporting system and their responsibility for reporting incidents.
- There were 26 serious incidents requiring investigation reported in maternity services at NorthwickPark Hospital and 7 at Ealing Hospital reported by the trust between August 2014 and July 2015.11 of the 26 which occurred at Northwick Park were unexpected admission to the Neonatal Intensive Care Unit (NICU).
- Serious incidents were reviewed on a weekly basis to decide about the type of investigation to initiate.
- We saw investigations of serious incidents, such as unplanned admission to NICU. A multi-disciplinary team contributed to the investigation, including a consultant obstetrician and consultant neonatologist when appropriate. There was a review of contributory factors as to why the incident happened. This included the patient's history, clinical and service issues. We noted that therewere recommendations for the way forward and lessons learned. Actions included meeting with the clinicians involved in the incident and recommendations for audits to be conducted to prevent the possibility of the incident happening again in the future. Findings were presented at the obstetric clinical governance meeting.
- Staff at Ealing Hospital told usthat theyhad not attended a risk management meeting since the merger with Northwick Park Hospital in July 2015.
- The trust had an electronic incident reporting system in place. Staff said that they could access the hospital's incident reporting system, and understood their responsibilities in regard to this. Staff could describe to us what constituted an incident and when they would raise one. Six midwives, junior and middle grade doctors we spoke with told us they did not always get direct feedback after reporting incidents.
- There was evidence that learning from incidents took place and changes in practice agreed subsequently. For example, following an incident which resulted in an unplanned admission to intensive care, the policy for managing and admitting seriously ill patients was reviewed and changes made
- We were also informed that there had been two serious incidents reported, one of which was a bladder injury

during a caesarean section, in the four weeks prior to our inspection (August to September 2015). At the time of our inspection these incidents were under investigation.

- Mortality and Morbidity meetings were being held monthly at Northwick Park Hospital. We reviewed minutes from these meetings. These reflected discussions and case reviews by multidisciplinary team members to consider any changes in practice needed to improve outcomes for patients.
- Senior staff mentioned the Duty of Candour in discussions with us. However, it was not evident from our discussions with less senior staff that they had an awareness of their responsibilities under the new legislation
- We did not see any information for staff relating to their responsibilities under Duty of Candour and it was not mentioned in any of the team meeting minutes we reviewed for the past 6 months.

Safety thermometer

- The NHS Patient Safety Thermometer is a local improvement tool for measuring, monitoring and analysing patient harm and 'harm free' care. This enabled measurement of the proportion of patients that were kept 'harm free' from pressure ulcers, falls, and urine infections (in patients with a catheter) and venous thromboembolism
- We found that NHS Safety Thermometer results were not visible to patients and visitors throughout the service.
- We requested the results of the safety thermometer for the service, however this was not provided.

Cleanliness, infection control and hygiene

- There had been no recorded Clostridium difficile and MRSA Bacteraemia incidents identified within maternity prior to inspection.
- Records confirmed robust domestic cleaning schedules and most clinical areas we visited appeared visibly clean.
- However, we found the early pregnancy unit at Northwick Park Hospital looked untidy and not very clean. We asked a manager for the daily cleaning schedules and were provided with records of cleaning for 3 September 2015, one month prior to our visit but nothing more recent.
- Support workers and midwifery staff had responsibility for certain daily cleaning tasks. Daily equipment checks did incorporate cleaning of the equipment. There was a sticker system to determine what equipment had been cleaned and when but we found this was not consistent across the service. For example, on Florence Ward we observed that the adult resuscitation equipment and neonatal resuscitaire did not have stickers indicating when they had been cleaned. A midwife told us that both resuscitaires were cleaned daily when they were checked; however labels were not used on that ward.
- Staff complied with the trust's infection control polices and protocols. Staff practiced good hand hygiene, used personal protective equipment appropriately, and wore their uniforms correctly with sleeves above their elbows.
- We were told every unit had a monthly hand hygiene audit, which demonstrated good hand hygiene. We requested the results of the audits; however we did not receive these but were subsequentlytold by the trust that results were displayed on KPI dashboardsfor inpatient areas.
- Feedback from people using the services indicated they were mostly satisfied with the cleanliness of the wards, clinics,bathrooms and toilet facilities at both Northwick Park and Ealing hospital. Comments made included "the cleaners come around at least twice a day and the staff clean their hands between patients.

Environment and equipment

- Each inpatient area had a buzzer entry system. Visitors are required to use the intercom and identify themselves upon arrival before they could access the ward. Staff had swipe card access.
- Most areas we visited were bright, clear of clutter, and well organised.
- Staff shared concerns with us that the Day Assessment Unit (DAU) at Northwick Park Hospital was too hot and that chairs used for patients having CTGs were difficult to manoeuvre. We noticed that the reclining mechanism on these chairs was broken. This was hazardous to both patients and staff. We found the DAU very hot;the temperature exceeded 28 degrees on most days from 1 October 2015. We spoke with a senior manager about this. We were told that they were not aware of any issues to do with the chairs. The senior manager arranged for portable air-conditioning units to be installed in the DAU

and for the chairs to be assessed. During our unannounced inspection we asked staff whether the environment in the DAU had improved. We were told that it had not.

- We looked at various pieces of equipment throughout the service and found that they were properly maintained. We saw they had a Portable Appliance Test (PAT) or a maintenance service in the past year. This included baby scales, a blood pressure machine and a neonatal resuscitaire.
- Resuscitation equipment for adults and babies was available throughout the service and was being maintained appropriately.
- There were Cardiotocograph (CTG) machines to allow for electronic monitoring of the fetal heart during pregnancy and labour available throughout the service.
- The equipment and environment in the obstetric theatres at Northwick Park Hospital had been well maintained and checked twice a day
- We found that scanning equipment in the ultra sound departments was being maintained and replaced in accordance with The Royal College of Radiologists; Standards for the provision of an ultrasound service standards (2014).

Medicines

- Records confirmed that staff regularly checked controlled drugs. Medications for resuscitation were also checked with the emergency equipment.
- Medicines were mostly stored securely throughout the service. However, we found that the door to the room where medications were stored for Edith ward was not always kept locked. We were told by staff that the room got very hot and would cause the external fridge thermometer to malfunction, therefore the door had to be propped open to help regulate the room temperature. We found that the room temperature where medication was being stored was not being recorded.
- The medicines fridge on Florence ward was out of use. We were told that by a midwife that the fridge had been out of use for at least five days before our visit. They went on to say that the room where the fridge was kept was very hot and that this had caused the fridge to malfunction. The medication had therefore been removed and stored in the fridge on Edith ward.
- Records indicated that the fridge on Edith ward had malfunctioned on a number of occasions. Staff on Edith ward told us this was due to the room where the fridge was kept being too hot. We saw that appropriate action had been taken to manage the medication when faults occurred with the fridges.
- We reviewed medication charts and found that they had been signed and dated, however the doctors and midwives did not print their names, therefore it was difficult to determine who had prescribed the medication as the signatures were difficult to read.
- At Ealing Hospital, we found the medicines fridge in the antenatal unit contained out of date drugs. If used, they could have an adverse effect on the patient or not work. We were told pharmacy would be contacted to collect the out of date items.

Records

- All pregnant women receiving services carried their own hand-held notes.
- On each ward we reviewed a small sample of nursing and medical records. We found the majority of the records were clear, logical and concise. Entries had been dated and signed.
- We found that patients' risk assessments were completed in care records. In maternity services, we found that patient's venous thromboembolism (VTE) risk assessments had been completed.However, some birth plans had not been completed. This meant that women may not always have had the opportunity to discuss their choices.
- We requested a copy of audits undertaken of the compliance of the HSA1 paperwork for termination of pregnancy required by the Department of Health; however we did not receive it at the time of inspection. We reviewed one HSA1 form that had been completed in line with the Abortion Act 1967. HSA4 forms were completed and a copy sent to Department of Health and a copy was kept with the medical records.
- Staff we spoke with at Ealing Hospital told us audits were not undertaken. Therefore, the service was not assessing compliance with national standards and benchmarking.

Safeguarding

- There were up-to-date safeguarding policies and procedures in place which incorporated relevant

guidance and legislation. Staff told us they could access these via the intranet. However, on the day of the visit to Ealing Hospital a senior member of staff was unable to access up to date guidance.

- The mandatory training programme for staff within the maternity and gynaecology service included level 3 safeguarding children training with annual updates. There were specialist midwives who provided support and advice to staff when caring for women with safeguarding concerns. Completion of level 3 safeguarding adults and children training was below the trust target of 90%; overall for the Women's Directorate, 69% of staff at Northwick Park and 44% at Ealing Hospital had completed this training.
- We were told that all women wererisk assessed for social vulnerability at bookingand midwives followed up those that did not attend for antenatal care.
- Managers and staff demonstrated understanding of the safeguarding process and concerns were identified on the IT system.
- The Jade Team was a group of midwives employed to provide care to vulnerable women. They communicated with the trust lead for safeguarding and provided support to staff in the maternity service. They also liaised with health visitors, social workers and community midwives,

Mandatory training

- There was 87% compliance with mandatory training across the maternity service and approximately 60% compliance across the gynaecology service. Mandatory training subjects included safeguarding adults and children, moving and handling, infection control, health and safety and information governance. Compliance with certain mandatory training subjects needed improvement. This included safeguarding training at level 3 and infection control,which were below the Trusts target level of 90%.
- Maternity staff received additional mandatory training which included obstetric emergencies and breastfeeding training. Obstetric emergencies were also practiced by live skills and drills throughout the service.
- Training was available online using e-learning as well as face-to-face.

Assessing and responding to patient risk

- The trust provided a Rapid Response Team (RRT) to enhance the care of acutely ill patients in hospital. The team were available 24 hours a day to attend any medical emergency or unwell patients in the hospital. Staff were aware of the RRT and were able to tell us how to contact the team.
- Gynaecology areas were using the National Early Warning Score (NEWS) system to record patient observations and scores. When completed, early warning tools generate a score through the combination of a selection of routine patient observations, such as heart rate and blood pressure. These tools were developed and introduced nationally to standardise the assessment of illness severity and determine the need for escalation.
- In maternity services, the Maternal Early Warning Score (MEWS) and Neonatal Early Warning Score (NEWS) system was in place for babies. We saw that MEWS and NEWS were used to identify deteriorating patients and ensure that they were seen quickly by a doctor.
- The "World Health Organisation (WHO) Surgical Checklist, Five Steps to Safer Surgery" was in place throughout the service. We checked and found staff used the tool correctly and were familiar with the process.
- We reviewed eight sets of patient records and noted that there was no documentation to confirm that a 'fresh eye' check was undertaken routinely, throughout labour. A matron on the delivery suite at Northwick Park Hospital confirmed our findings. Fresh eyes practice means that another midwife, usually the labour ward lead, reviews the cardiotocograph (CTG) traces hourly. CTGs monitor fetal heart rate.

Midwifery staffing

- 12 staff members, across the service and from various professions at Northwick Park Hospital, told us that staffing was a concern. One senior doctor said the lack of midwifery and nursing staff was an issue which, on occasions caused significant delay with starting elective caesarean sections as there were not enough staff to enable the procedure to be carried out safely. Three patients we spoke with told us their inductions had been delayed due to lack of staff on shift. However, they told us that, despite this, their care was good.
- We were told that, on occasions midwives working the night shift at Northwick Park Hospitalwould have to

scrub to assist in the theatre due to lack of nursing staff but not all the midwives were trained to scrub. We noted that the lack of night staff to cover theatres was on the risk register.

- Midwives told us that the service had stopped using agency staff at Northwick Park Hospital and, as a result, staff were being moved around to cover shortages. Staff told us that, in theiropinion,this was impacting on care, especially on Florence Ward as staffing levels were low due to midwives being deployed to the delivery suite.
- Staff across all units at Northwick Park Hospital raised concern to us that they were often unable to take their breaks due to being short staffed and too busy.
- At Ealing Hospital any shortfalls on shifts were covered by the department's own staff working on the nursing bank, so risks associated with employing temporary staff were minimised. Midwifery and nursing staff were very flexible and worked hard to support each other. They all had a strong commitment to their jobs.
- According to the maternity dashboard for April to June 2015, the total whole time equivalents budgeted for the maternity service was 199 posts. The number of vacancies was 6.5% in September 2015. Bank staff were being used to cover staff shortages across the service. This issue was not on the units risk register.
- Handover of patients between staff at Northwick Park Hospital was well-structured and staff communicated effectively with one another.
- According to the maternity dashboard for April to June 2015, the midwife to birth ratio (1:28) was the same as the nationally recommended workforce figure at Northwick Park Hospital. The Royal College of Obstetricians "Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007" standards state that, "The minimum midwife-to-woman ratio is 1:28 for safe level of service to ensure the capacity to achieve one-to-one care in labour". Staff confirmed that women received one-to-one care in labour; however, they reportedbeing under pressure in achieving this. This was due to a combination of factors including vacancies across the service andstaff sickness. We found that in August and September 2015, 98% of women received one-to-one care in labour.
- Staffing levels on delivery suite, Edith and Florence wards at Northwick Park Hospital were displayed and included expected staffing numbers by role and actual numbers for each shift. We noted on some days during the inspection there were less midwives and maternity assistants on duty than planned. During our announced visit to the service we noted that the delivery suite was supposed to have 12 midwives on duty working a long day, however there were only 9 midwives available. That night 11 midwives should have been on duty however, they were 1 midwife sh. A midwife told us that senior managers had been informed of the issue with staffing. However, senior managerssaid that the staffing levels were still safe. Therefore, additional staffing had not been arranged.
- One to one care during labour was good; around 98% had been reported in August and September 2015.

Medical staffing

- The directorate employed 47 WTE medical staff. In relation to middle grade and junior doctors, there was a good skill mix on duty at all times.
- The service was non-compliant with "The Royal College of Obstetricians: Safer Childbirth; Minimum Standards for organisation and delivery of care in labour, 2007" standards which state that, any unit with more than 5000 deliveries per year requires 168 hours of consultant presence per week. Northwick Park Hospital is benchmarked for over 5000 deliveries per year and has 132 hours of consultant presence per week. Therefore the trust did not meet this standard. This was on the Directorates Risk Register and there were plans to increase the number of hours to 168 by 2017.

Medical and theatre staffing

- Consultants were resident in the labour ward 24 hours on four days a week and via on-call rotas from home out of hours three nights a week. The obstetric theatres were managed by the maternity service with full anaesthetic support.
- Staff we spoke with said there were insufficient nurses to staff the two theatres at Northwick Park Hospitalappropriately, there were not enough nurses to scrub. Therefore, only one theatre was open. Midwives were used to scrub in theatre which depleted them from the delivery suite. This is not in accordance with The College of Operating Department Practitioners, The Royal College of Midwives and Association for Perioperative Practice in A Consensus Statement (2009), which states that "the midwife should not be expected to provide instrument/scrub assistance or act as the assistant to the obstetrician."

- During the inspection we noticed, on two days there were delays in starting the elective theatre lists. We were told this was due to lack of scrub nurse.

Major incident awareness and training

- There was a trust wide protocol for responding to major incidents, the policy was known by staff who confirmed they would be directed to the action they would be required to take.
- Staff had access to information about major incidents on the trust's intranet.

Are maternity and gynaecology services effective?

Requires improvement

Patient's were being cared for in accordance with national guidance. We found handover on the delivery suite very good. Staff had the right qualifications, skills, knowledge and experience to do their job. However, we found that during labour, the baby's heart rate was not always being reviewed by a second person and women's pain scores were not always recorded.

Staff had access to guidance, policies and procedures via the trust intranet. However, on the day of the visit to the unit at Ealing Hospital,staff wereunable to access the most recent copies of guidelines.

We found that pain scores were not recorded in the care records we looked at across the service.

Three of the five National Neonatal Audit Programme (NNAP) questions were below the national standard for Northwick Park.

We were informed that maternity postnatal readmissions, which appeared on the maternity dashboard, were not reviewed monthly however they were audited. We requested a copy of the audit but did not receive it, with the last audit having been conducted between April to June 2015. We were also told that the service recognised that there was a need to do these audits more frequently due to the high number of re-admissions and the new postnatal matron informed us that she was going to undertake this. The staff we spoke with told us the service did not undertake many audits to benchmark the service.

The Trust set a goal of 1.5% of births to be delivered at home. From the information presented to us, this was not being achieved. In September 2015 0.7% of births occurred at home.

Multi-disciplinary team working across disciplines was very good at Northwick Park Hospital, and consent to care and treatment was obtained in line with relevant legislation and guidance. There were also policies and procedures in place which were based on up-to-date evidence-based guidance.

Staff at Ealing Hospital were not following the latest guidelines in relation to medical management of miscarriage.

At Ealing Hospital we found no evidence of staff across the services working together inside the hospital. Staff we spoke with told us there were no multidisciplinary (MDT) team meetings. Staff across the service also told us that there were no general team meetings.

Records confirmed that asignificantpercentage of staff on Florence ward, maternity assistants and specialist midwives had not completed an appraisal in the past 12 months.

Gynaecology staff at Ealing Hospital told us that they had not had training on consent, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DOLs). The trust had policies in place regarding these subjects and however, staff were inaccessible to access them via the intranet on the day of the inspection. This meant that staff may not be up to date on current practices in regards to consent, DOLs and MCA.

Evidence-based care and treatment

- Staff had access to guidance, policies and procedures via the trust intranet. However, on the day of the visit to the unit at Ealing Hospital, a senior staff member was unable to access the most recent copies of guidelines.
- We found from our discussions and from observations that care was being provided in line with the National Institute of Health and Care Excellence (NICE) Quality Standard 22. This quality standard covers the antenatal care of all pregnant women up to 42 weeks of pregnancy, in all settings that provide routine antenatal care, including primary, community and hospital-based care.
- We found sufficient evidence to demonstrate that women were being cared for in accordance with NICE

Quality Standard 190 Intrapartum care. This included having a choice as to where to have their baby, care throughout their labour, monitoring during labour and care of the new born baby.

- We reviewed eight clinical records and found that a 'fresh eyes' approach was not used to peer review electronic recordings of the baby's heart rate. This involved a second person assessing the CTG monitoring against certain criteria to confirm that the baby was coping with the labour.
- The staff we spoke with were unable to provide us with evidence of audits such as record keeping. Staff at Ealing Hospital told us that audits had not been completed since the trustmerger. We were told that a member of staff had been recently employed to undertake audits for the service.
- We found from our discussions and from observations that care was being provided in line with the National Institute of Health and Care Excellence (NICE) guidelines in regards to ectopic pregnancy. However, found that the care pathway for medical management of incomplete or missed miscarriage was not being followed at Ealing Hospital.

Pain relief

- The patients we spoke with in all clinical areas said that staff assessed their pain, offered them choice of pain relief when required and most said that these medicines were given in a timely way. We found that pain scores were not recorded in the care records we looked at. Recording pain scores help diagnose and treat pain more appropriately in patients.
- Staff confirmed that anaesthetists responded promptly to staff requests for specialist pain relief, such as epidurals. There was an anaesthetist on duty for the delivery suite and theatres 24 hours a day
- We were told that women attending for gynaecology procedures would be prescribed pain relief for before and after the procedure and that it could include a local anaesthetic

Nutrition and hydration

- At Northwick Park Hospital in-patients all had a jug of water beside them and told us that food choice and availability was good. There were regular meal times with a variety of food choices. However three diabetic patients told us that they had been offered sugar for their hot drinks and were told that there was no alternative, such as a sweetener, available.
- The maternity service hadUnited Nations International Children's Emergency Fund, (UNICEF) full accreditationbaby friendly status. This initiative accredits maternity facilities that adopt internationally recognised standards of best practice in the care of mothers and babies. Stage 2 accreditation is achieved when a service demonstrates that all staff have been educated according to the role.
- An infant feeding midwife was responsible for the oversight of infant feeding. The service promoted breastfeeding and the important health benefits now known to exist for both the mother and the baby.
- Between April to June 2015 breastfeeding was over 83% following delivery, better than the England average. Breastfeeding at discharge from hospital during this period was over 86%.
- We observed feeding information on display throughout the service, this included the advertising of additional supportive services.

Patient outcomes

- The proportion of delivery methods were mostly in line with national expectations.
- Normal births were promoted; the rate of normal unassisted births averaged at over 60% from January to December 2014. This was equal to the normal birth rate in England.
- The rate of non-elective caesareans was high, and averaged 19% between January to December 2014 which accounted for a high number of births. This was 4% higher (worse) than the national average in England during that period. We were not aware of any actions to improve on this.
- The Trust set a goal of 1.5% of births to be delivered at home each month. From the information presented to us, this was not being achieved. In September 2015 0.7% of births occurred at home. We were told that there were only two home birth midwives and, as a result, they had to be on-call every other day, which was "A struggle" and "Not safe" for women delivering. We were told the homebirths team was going to be "dissolved" at the end of December 2015 due to lack to lack of staff.
- Three of the five National Neonatal Audit Programme (NNAP) questions were below the national standard for

Northwick Park. This included not meeting the national standard for babies having their temperature taken within an hour of birth, eligible babies not having Retinopathy of Prematurity screening within the set time frame and parents not having a consultation with a senior member of the neonatal team within 24 hours of admission.(The audit took place in 2013 and was published in October 2014).

- Two of the five NNAP audit questions had good results. The hospital received 91% for women being given antenatal steroids before delivering a premature baby, and 95% for babies who had receiving their mother's milk when discharged from the neonatal unit.
- There was a 'Guideline for Infant Feeding Policy' which was up to date. The infant feeding midwife had also proposed that maternity assistants be trained in lactation support and was awaiting approval from management.
- We reviewed a copy of the maternity and gynaecology performance dashboard from April 2014 up to September 2015. This contained evidence of monitoring of patient outcomes, staffing, skills mix and risk management
- Unexpected admissions to NICU was being monitored on a monthly basis. We were provided with the data for 2014/15.
- We were informed that maternity postnatal readmissions, which appeared on the maternity dashboard, were not reviewed monthly however they were audited. We requested a copy of the audit but did not receive it, with the last audit having been conducted between April to June 2015. We were also told that the service recognised that there was a need to do these audits more frequently due to the high number of re-admissions and the new postnatal matron informed us that she was going to undertake this.
- There was an extensive care pathway in place for women attending the early pregnancy unit at Ealing Hospital. This included providing the patient, and GP with results and outcome. Contact details of the unit are provided in case the patient or GP needs further advice.

Competent staff

- Records confirmed that asignificantpercentage of staff on Florence ward, maternity assistants and specialist midwives at Northwick Park Hospital had not completed an appraisal in the past 12 months.
- We found conflicting information in relation to the ratio of Supervisors of Midwives (SOMs) to midwives. The Women's Directorate Risk Register dated 16 October 2015 showed that the ratio for Supervisors of Midwives (SOMs) to midwives was 1:20 making the trust non-compliant with Nursing and Midwifery Council recommendations. However, the staff we spoke to told us that the ratio was 1:14.We requested the Local Supervising Authorities' (LSA) SOM report.The last report was produced in July 2015. It said that the SOM to midwife ratio was 1:20 at that time. The report also found that the service was not meeting 2 out of 4 of the areas the LSA looked at. We were provided with an action plan with improvements required, some of which had been actioned.
- We were told that, on occasion's midwives working the night shift at Northwick Park would have to scrub to assist in the theatre due to lack of nursing staff. We were also told that the majority of the midwives had not been trained how to scrub.
- Staff told us that they were supported to gain additional qualifications and to maintain their continual professional development.
- We spoke with newly qualified midwives who told us they had undergone a local induction including the completion of a competency framework and that they were allocated a SOM during this period. They told us that theywere well supported as did student midwives.
- There were two whole time equivalent (WTE) practice development midwives who managed the preceptorship programme, to support and guide newly qualified midwives
- Support workers underwent trust competencies. One support worker told us they had been supported to complete a foundation degree in care and support.
- Junior doctors told us theywere supported by the senior doctors and could approach them at any time if they had concerns.

Multidisciplinary working

- We observed that staff across maternity service at Northwick Park Hospital worked effectively together inside the hospital and there were links with the community.There were multidisciplinary (MDT) team meetings and discussions where required which

ensured effective care and treatment plans and handover of patient care. Staff attending MDT meetings included midwives, community and specialist midwives, specialist registers and consultants.

- We observed the handover on the delivery suite at Northwick Park Hospital and found it to be very good. Handover was attended by the multi-disciplinary team, who each took part in proceedings.
- We found that the gynaecology staff on the early pregnancy unity (EPU) at Northwick Park Hospital were not having regular team or MDT meetings. The staff we spoke with were also unable to provide evidence of attendance to the monthly clinical risk meetings.
- At Ealing Hospital we found no evidence of staff across the services working together inside the hospital. Staff we spoke with told us there were no multidisciplinary (MDT) team meetings. Staff across the service also told us that there were no general team meetings.
- Care and treatment plans were documented and communicated to relevant health care professionals, such as GPs and health visitors, to ensure continuity of care.
- There were multidisciplinary pathways developed for the care of women with suspected fetal abnormalities. The midwifery, nursing, sonography, chaplaincy and medical staff worked together to ensure confidentiality and sensitive care for the women her partner and family.
- Most of the staff we spoke to stated that there were good working relationships between professions.

Seven-day services

- The maternity service was accessible 24/7 via the triage facility at Northwick Park Hospital.
- There was a supervisor of midwives (SOM) available 24 hours a day, seven days a week through an on-call rota system which ensured that midwives had access to a SOM at all times.
- There was an anaesthetist and consultant available 24 hours a day 7 days per week, 3 nights the consultant cover was provided via an on call rota system.
- There was a named pharmacist available Monday to Friday and on-call out of hours.
- Gynaecology scans are available from 9am-9pm Monday to Saturday, for inpatients from 10am-11am on Sundays and from 10am-2pm on bank holidays.
- We were told that the radiology services for maternity and gynaecology patients was not available 24/7. However, women could have emergency scans on labour ward and that there was a senior member of radiology staff on call for advice.
- The antenatal service at Ealing Hospital was accessible Monday to Friday and ultrasounds available Monday to Friday from 9am-5pm and weekends from 9am-1pm. On the day we visited, antenatal ultrasound clinic appeared to be very quiet and a staff member we spoke with informed us that at times they only had 3 appointments in a day.
- Early pregnancy unit was open Monday to Friday from 8.30am-5pm and Saturdays from 9am-1pm

Access to information

- GPs were able to make direct referrals to the Gynaecology Assessment unit.
- There was a specialist midwife for bereavement who provided information to women following pregnancy loss regarding the disposal of the pregnancy remains. Women were asked to sign a form indicating their wishes. We saw a detailed check list was to be completed and included in women's records. This indicated where information and discussion had taken place about funeral arrangements, if the baby was born before the 24th week of pregnancy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Consent to care and treatment was obtained in line with national legislation and guidance, including the Mental Capacity Act.
- Training on consent, the Mental Capacity Act, Deprivation of Liberty Safeguards (DOLs) and learning disability was part of mandatory training for all staff. The trust had policies in place regarding these subjects and they were accessible to staff via the intranet. Staff we spoke with at Northwick Park Hospital told us that they could access the intranet, and demonstrated adequate knowledge about these subject areas.
- Gynaecology staff at Ealing Hospital told us that they had not had training on consent, the Mental Capacity Act (MCA), Deprivation of Liberty Safeguards (DOLs). The trust had policies in place regarding these subjects and

however, staff were inaccessible to access them via the intranet on the day of the inspection. This meant that staff may not be up to date on current practices in regards to consent, DOLs and MCA.

Are maternity and gynaecology services caring?

Good

Feedback from people who used the service and those who were close to them was positive.People were treated with dignity, respect and kindness during all interactions with staff and relationships with staff were positive.

Women told us that they were well informed, understood their care and treatment and were able to ask staff if they were not sure about something.

Staff responded compassionately when people needed help and supported them and their babies to meet their personal needs. Staff helped people and those close to them to cope emotionally with their care and treatment.

Compassionate care

- We observed ward areas, listened to focus groups and individual staff who were involved in patient care and found that staff responded compassionately when people needed help, and supported them to meet their needs.
- Patients we spoke with across the service were mostly positive about staff. One person commented that the midwives and staff were, “Fantastic”, and another said that their care was, “very good” and that staff were, “polite and caring”.
- Between October 2014 and July 2015 the “Friends and Family Test” (FFT) scores for recommending antenatal and birth services at London North West Healthcare NHS Trust(after merger with Ealing) varied but scores were worse than the England average for most months. Scores were below national averages for postnatal wards but postnatal community services were higher than the national average.
- Trust scores in the “CQC Woman’s Experience of maternity services survey” carried out in 2013 forthe trust(prior to merger with Ealing)were the same as other trusts for 9 measures and worse than other trusts for 8 measures.
- Trust scores in the “CQC Woman’s Experience of maternity services survey” carried out in 2013 for Ealing Hospital Trust were the same as other trusts for 15 measures, better than other trusts for 1 measure and worse than other trusts for 1 measure.
- We observed display boards in some areas which contained numerous and recent thank you cards from patients and families for the care they had received.
- Across the service we found that staff ensured patient’s dignity and respect. We observed that patients could close their curtains around their beds in bays for privacy and that staff knocked on doors before entering patient rooms.

Understanding and involvement of patients and those close to them

- The antenatal records we checked did not have birth plans in place. However across the service patients told us that they were well informed and were involved in decisions about their care or treatment. One patient and her partner told us that they were “Kept informed of everything”, and another said, “They always tell me what they are doing or what is going to happen”.
- We observed a women who was about to have an elective caesarean section being treated compassionately and the care being explained in a way she could understand A patient told us, "The staff explained the procedure very clearly.
- There were a range of information leaflets and posters on display in the antenatal clinic at Ealing Hospital. Many of the posters had been translated into other languages.

Emotional support

- There was a specialist bereavement midwife in post to support parents in cases of stillbirth or neonatal death.
- There was a trust wide spiritual care and chaplaincy team available to patients, families and staff of all faiths and none. This was available 24 hours a day 7 days per week
- We were advised by midwives that women would be referred to their GP for counselling following a pregnancy loss, if required as the trust did not have a counsellor at the time of the inspection.
- We were advised by midwives that women had access to de-briefing from midwives following traumatic labour experience if requested

- Memorial services were held annually in the chapel for families who had experienced pregnancy loss.

Are maternity and gynaecology services responsive?

Requires improvement

The area used for triaging patients was not big enough to accommodate patient flow. There was also a chance that confidential conversations could be overheard between midwives and women in this area and in the bereavement room. There were delays in starting inductions and elective caesarean sections due to lack of staffing. Midwives were used to assist during caesarean sections at night due to a lack of nurses.

Patients told us that, on occasions, the antenatal clinic at Northwick Park Hospital would run up to 2 hours late due to lack of staff.

Birth plans were not always completed. This meant women may not have the opportunity to express their wishes and have them acted upon.

Complaints about maternity and gynaecology services were initially managed and resolved locally. If complaints could not be resolved at ward level, there was a system in place to investigate and respond, including giving an apology.

Between October 2014 to September 2015 the service received 64 complaints. 13 of these were still open and being investigated at the time of the inspection. Some complaints had been open for over two months.

Patients attending for ultrasounds at Ealing Hospital would not be given the opportunity to decide whether they wanted to be treated by a male or female sonographer prior to attending their appointment. This resulted in wasted appointments and scans being delayed.

Service planning and delivery to meet the needs of local people

- There were a number of specialist nurses/midwives available to support women with specific requirements including female genital mutilation, infant feeding, and safeguarding and bereavement specialists.
- There was no smoking cessation midwife in post; however the public health specialist midwife had involvement with women who were smokers
- The birthing rooms at Northwick Park Hospital all had en-suite bathrooms. Some had birthing balls and mood lighting.
- There was a room at the end of the delivery suite at Northwick Park Hospital used for families experiencing bereavement. We were able to access this room during our visit. The room was of a decent size with comfortable surroundings. However, staff told us the room was not sound proof and therefore it was possible that families who had experienced bereavement could hear the sounds of labouring women and crying babies. We raised this as a concern with a senior manager and was told that the service was working with West London Stillbirths and neonatal death charity (Sands) to improve bereavement services, which included sound proofing the room. We were told that there was no other suitable place for families to be moved to without doing major structural improvements.
- There were a range of information leaflets available in ward and clinic areas.
- At Ealing Hospitalwe were told that there was a male sonographer on duty on Wednesday afternoons, Thursdays and Fridays. We were told that patients would not be informed of this, however, when they arrived if they stated that they would prefer to have a female sonographer they would be booked for another day. Therefore, the patients scan would be delayed and the patient may be inconvenienced by having to return to the clinic on another day. Also the scan slot would be wasted.
- Appointment slots with the sonographer were not being utilised. We were told that on some days only three patients were seen.

Access and flow

- Triage was open at all times at Northwick Park Hospital. Women who suspected they were in labour were assessed by a midwife. The triage became quite congested when busy and it was difficult for women and their partners to have confidential conversations with staff. We were told that the triage process was under review. Staff raised concerns about one midwife covering triage and observation area at same time.
- Staff and patients told us that there were frequent delays in starting elective caesarean sections, induction

of labour and that there were delays in discharge. We were told this was due to staff shortage. We were told that, on some occasions, midwives working the night shift would have to scrub to assist in the theatre due to lack of nursing staff. We were also told that the majority of the midwives had not been trained how to scrub.

- Patients told us that, on occasions, the antenatal clinic at Northwick Park Hospital would run up to 2 hours late due to lack of staff.
- Bed occupancy rates in maternity services from October 2014 to March 1015 were between approximately 60-63%. This was slightly higher than the England average of 59%.
- We requested the current percentages of women seen in the labour ward within 30 minutes by a midwife, and the percentage seen by a consultant within 60 minutes, to determine timeliness of assessment. This information however was not being recorded.
- Women could self-refer, or be referred by their GP or midwife for a range of problems for example, bleeding, a change in their baby's movements, abdominal pains, or for advice.
- The trust had a policy which outlined planned actions in the event that the maternity unit required closure. Between January 2014 and June 2015 the maternity unit had closed a total of four times. Two closures were due to a fire and flood. The most recent closures were due to lack of beds/cots.
- There were regular call bell audits which determined the length of time it took for staff to answer patient call bells which showed good outcomes. The most recent "CQC Survey of Women's Experiences of Maternity Services 2013" demonstrated that the length of time it took for staff to answer patient call bells (7.4 minutes) was in line with most other Trusts.
- The service monitored the percentage of women accessing antenatal care in accordance with "National Institute of Health and Clinical Excellence; Antenatal Care 2008" guidance, which states that booking is ideally achieved by 10 weeks of pregnancy.According to the data we were given annually 71% of pregnant women were booked within 10 weeks.
- Pregnant women had prompt access to maternity services between July and September 2015; over 95% of women were booked for antenatal care by 12 weeks and 6 days gestation. This was in line with the trust target and exceeded the national target of 90%. We were not provided with the results prior to July 2015.
- We reviewed the trust's Pregnancy Loss policy, which included fetal anomaly. We found that there was an admission criteria based on stage of pregnancy, with women over 20 weeks being admitted to the deliver suite.
- The trust target for 18 week Referral to Treatment Times (RTT) for gynaecology patients was 92% for admitted patients. The service was meeting this target; between April to September 2015 at least 93% of the 18 week RTTs were met
- At Ealing Hospital Patients told us they were seen on time in the antenatal early pregnancy and ultrasound clinics and that there was good availability of appointments.
- The antenatal clinic is open Monday to Friday and ultrasounds available Monday to Friday from 9am-5pm and weekends from 9am-1pm. Early pregnancy unit was open Monday to Friday from 8.30am-5pm and Saturdays from 9am-1pm.

Meeting people's individual needs

- There was a dedicated team caring for teenagers and young parents to meet their specific needs. There was specialist support for women with a previous caesarean section and there was a VBAC (Vaginal Birth After Caesarean) programme. Other specialist support available included diabetic, female genital mutilation, bereavement and infant feeding.
- The care records we looked at did not contain completed birth plans. This meant that care needs of women at each stage of their pregnancy was not always acknowledged and may not be acted on as far as possible.
- The service had access to 24 hour translation services which included in-house interpreters and Language Line. There was a DVD in seven languages given to patients' accessing antenatal care. Further support services were available for those who were visually impaired, blind or deaf. Staff we spoke with were aware of how to access these services if needed.

- The service provided women and visitors with a range of supportive health education literature including leaflets and posters. In some areas leaflets had been translated in to other languages.
- There were posters displaying Supervisor of Midwife (SOM) information and contact details, should parents wish to have further support from the SOM team. This meant that parents were encouraged to be involved in their care and were provided with additional information to enhance their understanding of care and treatment.
- We found that throughout the service there was a lack of signage in other commonly spoken languages.
- The trust offered special diets which met people's individual needs, such as vegetarian, vegan, gluten-free and halal meals. However, three diabetic patients told us that there was a lack of artificial sweeteners available. Therefore, they had to have hot drinks without a sugar substitute.
- The Trust had employed a learning disability nurse specialist. Staff we spoke with were aware of the support this nurse specialist offered and knew how to access this support.
- The directorate's website had important information about key members of staff that may be involved in patient's care; this included the names of gynaecology consultants.

Learning from complaints and concerns

- The trust provided a leaflet for patients 'Listening, responding and improving your experience' which details the Patient Advice and Liaison service (PALS) service. Staff within the maternity service stated that they would also respond, where possible, immediately to concerns raised by women in an attempt to resolve the issue without the need for formal complaint.
- Most of the patients we spoke to were not clear about how they would go about making a complaint. They had not been provided with information about this.
- We observed display boards on ward areas reading, "You said, we did" which demonstrated that the service learnt from complaints and concerns where possible. However, these boards were not dated therefore it was unclear when the changes had been made.
- There were processes in place for responding to complaints. We reviewed a recent complaint and saw that the patient had received a timely response and an apology. We also saw evidence of learning and changes made to practice.
- The service monitored the amount of complaints received. Between October 2014 to September 2015 the service received 64 complaints. We saw the majority of the complaints had been investigated and that patients received an apology. Ho13 of these were still open and being investigated. Some complaints had been open for over 2 months. Poor care from staff was a theme of some complaints.

Are maternity and gynaecology services well-led?

Requires improvement

The Trust had a clear vision and strategy however the staff we spoke with did not demonstrate awareness or understanding of it. We saw the services' business plan for 2015 – 2016. It did not include the vision of the service.

Staff at Northwick Park Hospital described leadership and support from ward level and above up to the acting head of midwifery as good; we were told managers up to the level of acting head of midwifery were visible and approachable.

The staff we spoke to at Ealing Hospital told us they perceived that they were under-utilised and undervalued by the trust since the merger. We were told staff meetings were not held and that staff working at this hospital did not attend governance meetings or receive feedback.

We were concerned that the shortage of midwives and scrub nurseswas causing distress amongst staff, who were not aware of long-term plans to address these concerns.

We found that some of the risks we identified were not on the risk register, such as the room used for bereaved women on the delivery suite at Northwick Park Hospital.

Governance meetings were meant to be held monthly across the maternity and gynaecology service. However, we were onlyprovided with minutes of meetings held in May, June and September 2015. We reviewed the minutes of

these meetings which confirmed that some incident analysis was occurring as well as lessons learnt. However, there was no evidence of performance monitoring or guidance being reviewed as a result of incidents.

The service had a newsletter known as 'Risk News', which was used to provide staff with feedback from incidents on a monthly basis. Staff at Northwick Park Hospital told us that they received this newsletter regularly. Staff at Ealing Hospital told us they had never seen the newsletter.

We observed good multidisciplinary working relationships at Northwick Park Hospital, committed to providing women-centred care. This was not evident at Ealing Hospital.

Vision and strategy for this service

- The trust vision and strategy was not visible throughout the wards and corridors. Staff did not know and could not quote the vision.
- We were provided with the services business plan for 2015/16. There were clear objectives, which included an increase of consultant presence in the labour ward and a plan for stakeholder engagement. However there was no information about the vision of the service. We found that the business plan for the service lacked defined objectives in relation to the concerns known by the service. This included the on-going risks relating to triage process, midwifery staffing levels and the room used on the delivery suite for women suffering pregnancy loss and the day unit.Although the business plan did not have an action plan, we were provided with a copy of the grant application and plans for the re-development of the triage area.The grant application was dated June 2015. We were not provided information as to whether the application had been approved.
- There were short-term plans to respond to maternity staffing issues, such as having safety huddles and moving staff to areas of greater need. However, we were concerned that this was causing distress amongst staff, who were not aware of long-term plans to address these concerns.
- We were provided with a copy of the Midwifery Preceptorship Programme. We found that the Trusts vision and the objectives of the maternity service were not documented for review by newly qualified midwives joining the service.

Governance, risk management and quality measurement

- The maternity and gynaecology service had a governance structure in place. For example, Matrons and the consultant midwife reported to the acting head of midwifery, who reported to the divisional manager. Senior staff based at Northwick Park Hospital told us that there was effective reporting lines to the trust board. Staff we spoke with at Ealing Hospital were not aware of the governance arrangements.
- A Women's Directorate risk register was in use and monitored on a regular basis. There were processes in place for escalating risks to the trust board where required. We were concerned that some of the risks we identified were not on the register, such as the room used for bereaved women on the delivery suite at Northwick Park Hospital.
- The service used a quality dashboard that was reviewed on a monthly basis by the governance groups. This used a red/green flagging system to highlight areas of concern.
- There was a clinical risk manager for maternity services in post who was involved in the organisation of the risk management and governance meetings. However, staff at Ealing Hospital were not aware of these meetings.
- We were told that governance meetings were meant to be held monthly across the maternity and gynaecology service. However, we were onlyprovided with minutes of meetings held in May, June and September 2015. We reviewed the minutes of these meetings which confirmed that some incident analysis was occurring as well as lessons learnt. However, there was no evidence of performance monitoring or guidance being reviewed as a result of incidents.
- The service had a newsletter known as 'Risk News', which was used to provide staff with feedback from incidents on a monthly basis. Staff at Northwick Park Hospital told us that they received this newsletter regularly.Staff at Ealing Hospital told us they had never seen the newsletter.

Leadership of service

- Senior midwifery leaders (action HOM, Matrons) were visible and staff at Northwick Park Hospital told us they were approachable. Staff told us these leads involved them, especially in more recent months.

- Midwifery staff spoke positively about matrons at service level and told us that they were given opportunities to develop. We saw that staff were enthusiastic and motivated even though they told us they were “stretched”.
- We were told that the Acting Head of Midwifery hadaccessto the trust board via the Divisional Manager for Women's and Children's services.
- We were told all midwives had a named supervisor of midwives (SOM). The rate of SOM to midwife was meant to be 1:15; that is one supervisor to 15 midwives. However, we found conflicting information. According to the Local Supervising Authority (LSA) annual audit report at Northwick Park this was at 1:20 in July 2015 and according to the maternity dashboard this was 1:20 in August and September 2015. We noted that the trust had compiled an action plan in response to the LSA audit, dated October 2015. This stated that the rate of SOMs to midwives had improved and was 1:14 in October 2015. The Women’s and children dashboard dated 16 October 2015 stated the ratio of SOM to midwife was 1:20.This would not be reviewed and confirmed by LSA until November 2015.
- Staff told us that senior managers were visible. However, members of the trust board were not visible.
- We were told that the deputy HOM based at Ealing was visible and engaged. However, the staff we spoke on this site with told us they perceived themselves to be undervalued and left out since the trust merger. We were told that senior leaders were not visible at Ealing Hospital and that when staff from Ealing made suggestions about improvements to the service, they were not taken on board.
- The deputy HOM had access to the trust board and did meet with senior colleagues

Culture within the service

- The trust promoted a positive safety culture and encouraged incident reporting.
- From our discussions with staff and our observations, we saw a commitment to meeting the needs and experiences of people using the service.
- We observed good multidisciplinary working relationships at Northwick Park Hospital, committed to providing women-centred care. This was not evident at Ealing Hospital.
- We asked for details of how success was celebrated across the service, however this was not provided. The staff we spoke with told us the trusttook part in the excellence awards but that no one had beengiven an award since 2013.
- According to the maternity dashboard, staff sickness levels were above the trust target of 3% between July - September 2015. Staff sickness levels were moderate to high ranging from 3.91-5.06%.We requested but were not provided with the gynaecology dashboard for the past year.
- We were provided with the highlights from the most recent national staff survey which was carried out in 2014. Key issues arising from the survey included low appraisal rates, staff being bullied and harassed and poor compliance with Mandatory and Statutory Training (MAST). We were provided with a copy of the action plan to address these areas. However, improvement was still required in some of these areas across the maternity and gynaecology service.For example, the service was not meeting MAST targets.

Public engagement

- Patients, families and carers were encouraged to engage with the service. There were posters displaying how to do this and suggestion boxes were observed in some of the units.
- The details of the SOMs were displayed throughout the service reminding staff and patients about the service and encouraging them to get in contact.
- Open days were held so that women and their partners could tour the maternity unit. We saw one of these tours during the inspection and noted it was well attended.

Staff engagement

- Nursing and midwifery staff at Northwick Park Hospital reported positively on the level of engagement with their immediate line managers and medical staff. However, they voiced concerns about staffing levels and not being made aware of plans to improve this by senior managers.
- Staff we spoke with told us they were supported to undertake leadership programmes. We were told about a project undertaken by a member of staff to improve the waiting area for patients attending antenatal appointments. A presentation had been prepared for the board.

Maternity and gynaecology

- Staff told us the trust took part in the excellence awards, the trust's staff excellence awards are a way of recognising individuals and teams who go above and beyond the high standards expected. One administration staff told us she had received an award in 2013.
- Staff at Ealing Hospital told us that they did not feel engaged or valued by management. They told us they were not listened to or involved in service development.

Innovation, improvement and sustainability

- The service was establishing a women's service developmental group. This would look at the care process from point of birth to discharge.
- Student midwives won a poster competition for their poster which described 6 ways to help women relax during labour.

Services for children and young people

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

Information about the service

Children and young people's services at Northwick Park Hospital (NPH) consist of a children's ward for inpatient care called 'Jack's Place', a 24 bedded medical/surgical ward with 12 side rooms and 12 beds in bays.

The children's day care unit and outpatient area (Chaucer) at this hospital is a nine bedded area with out- patient facilities to provide surgical and medical day care to children and young people from birth to 16 years of age. The unit is open Monday to Friday between the hours of 8am and 6pm.

There is a dedicated children's Accident and Emergency (A&E) department within the main A&E and this has an observation unit adjacent to it.

The emergency inpatient and day care Sickle cell and Thalassaemia children's services are located at this hospital.

The neonatal intensive care unit (NICU) is a level two unit, for babies born prematurely or for new-born babies with other problems. NICU haa capacity to take up to 28babies, for which three cots were for Intensive care, five cots for high dependency care and the remainder are special care cots.

During the inspection, we visited the NICU, Jack's Place, Chaucer and outpatient's department on three occasions, we visited the children's accident and emergency department and the theatres recovery area for children on two occasions.

We spoke with six children and their parents or guardian(s), 30 staff including nursing staff, medical staff, play specialists, ward housekeepers and administrative and managerial staff.

We reviewed 12 sets of patient medical and nursing records and information requested by us and provided from the trust.

The inspection included the complete service including the transition arrangements for children transferring into adult services and the provision of care for children with long term conditions such as diabtes, epilepsy and asthma.

Services for children and young people

Summary of findings

Children and young people's services at this trust were rated as requires improvement except for caring which was good. The safeguarding children's procedures were robust with staff demonstrating how they were embedded into the service. However, the safeguarding policywas currently under review and the existing out of date policy was seen as a printed hardcopy across this service.

Items that were not compliant included out of date hard copies of policies seen in the Chaucer unit, and Control of Substances Hazardous to Health (COSHH) assessments not reviewed in line with policy changes implemented.

Staff informed the inspectors that they had instructions not to use agency staff. Staff shortages meant that staff had worked extra shifts which were seen on the e roster.

Senior staff had to physically seek out when children were admitted to an adult bed, as there was no flagging system. There were gaps in support arrangements for children with long term conditions e.g. epilepsy and no identified nurse specialist to support this group of patients who required information and support.

The service was not responsive in meeting the needs of children and young people when in the children's accident and emergency department, as the waiting time was reported as too long by parents we spoke with.

Six staff asked about the trust strategy were not all aware of local or trust wide strategies.

The arrangements for governance and performance management did not always work effectively, as items on the risk register did not reflect all the areas that require improvement identified by the inspectors e.g. COSHH.

The local leadership teams within the service were rated as required improvement as we saw policies as hardcopies that were significantly out of date and not the ratified policy.

We raised concerns about the lack of neonatal resuscitation equipment and resuscitaire in the accident and emergency department which senior staff resolved by transferring equipment from the closed neonatal unit at Ealing Hospital.

The service had achieved 93% of children being seen within 18 weeks of referral for treatment with 7% of patients breached over 18 weeks which did not meet the target.

Feedback from family members and children or young people we spoke with was positive about the care provided. Parents said that staff went the extra mile for their children and staff engaged children and parents in individualised plans of care.

Services were planned and delivered to meet the needs of the diverse population.

Services for children and young people

Are services for children and young people safe?

Requires improvement

Safety of the children's service required improvement because, although the safeguarding children's procedures were embedded and robust, additional policies and procedures reviewed as hardcopies in folders for staff were out of date.

The safeguarding policy is currently under review and the existing out of date policy was seen as a printed hardcopy across this service.

On review of the incident reports submitted, the action taken in response following investigation was oftena lessons learned briefing leaflet for staff within this service.

The management of medicines was seen on the risk register with frequent comments about changes but we could not be assured that lessons were learned.

There were notable staffing shortages for registered staff across the service with instructions not to recruit agency staff

We were told that staff work extra bank hours on top of their permanent contracts and agency staff cover on the children's ward had not been necessary for the past two years.

There was good evidence of the environmental refurbishment, equipment maintenance, record keeping and completing paediatric early warning signs (PEWS).

Incidents

- There were no never events reported in the children and young people's service in the last year. "Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented."
- The children's service reported 32 incidents through the online reporting system, called Datix between June 2014 and September 2015. The most common reported incidents were staffing levels not meeting children's acuity or dependency and issues with the administration and recording of medicines. National Reporting and Learning Service (NRLS) incident figures are for the merged trust which showed 7.1% incidents per 100 admissions which is fewer than the England average (8.4%) for the same period. The larger proportion, 93% of incidents were low or of no harm.
- On review of theserious and incident reports submitted, the action taken in response following investigation wasseen in a "learning lessons" staff brief leaflet shared within this service. We sawseveral serious incidents reported for this service through the datix electronic reporting system with the root cause analysis and completed recommendations.
- Staff we spoke with were aware of the requirements of reporting incidents and what constituted an incident and they could clearly be explain to us how to report an incident using the online incident reporting system.
- Incident reporting was shared through staff meetings, newsletters and governance meetings.Staff described feedback and talked about improvements following incidents.
- There were examples given to illustrate how Duty of Candour requirements were identified and the manager of each area was fully aware of the requirements of Duty of Candour and when letters had been sent.
- These were kept housed in a central database where we saw 871 incidents reported since August 2015 for the integrated service. The identified incidents related to staffing, discharge letters and interpreters not present which led to a cancelled appointment. We saw no evidence of sharing lessons learned across the trust.
- The Duty of Candour means that providers of healthcare services must be open and honest with service users and other 'relevant persons' (people acting lawfully on behalf of service users) when things go wrong with care and treatment, giving them reasonable support, truthful information and a written apology.
- The senior staff from the neonatal intensive care unit and the children's ward told us that they spoke with the families involved following any incident as standard practice and were open with them.
- Mortality and morbidity meetings are held monthly in the service and minutes had been examined. The last meeting was held in September 2015. The minutes of these meetings were shared with staff and included actions to take to improve staff learning following any incident.

Cleanliness, infection control and hygiene

- There were strict processes in place to prevent the potential spread of methicillin resistant staphylococcus aureus (MRSA). Testing for MRSA was standard, if a child had previously tested as positive, they were nursed in a side room until two negative results had been obtained. Screening for MRSA was audited for NICU and Jack's Place in September 2015.
- Monthly infection prevention and control (IPAC) audits took place across the service. The audits included hand hygiene, standard precautions, care of peripheral vascular device insertion and continuing care, patient equipment and environment. Compliance withkey trust policies (e.g. hand hygiene, PPE, isolation etc) had improved to 100% for September.We met with the infection prevention and control nurse who agreed with the results.
- The trust's hand hygiene audit undertaken in September on both the Neonatal Intensive Care Unit and Jack's Place Children's ward showed recent improvements to 100% compliance with trust hand hygiene practices.
- A monthly infection prevention and control safety cross was on display across the service. The cross demonstrated how many days the ward had been free of infection outbreaks for MRSA and clostridium difficile (C diff) that month. In this case, every day had been free of these healthcare acquired infections.
- Our observations during the inspection showed that the staff were mostly compliant with the trust's uniform policy and 'bare below the elbow' requirements. We saw medical staff on the neonatal unit wearing hair untied and wearing bracelets which is not in accordance with the trust policy. Senior staff challenged this behaviour before patient contact was made
- There were twelve side rooms that were used for children who were identified as immunosuppressed or requiring isolation. The use of the side rooms allowed them to be isolated from other children with communicable diseases.
- We examined thecleanliness audits andweekly cleaning schedules for across this service and found that they were completed correctly which was evidenced by the environment which appeared clean during the inspection.
- Patient Led Assessment of the Clinical Environment (PLACE) inspection was completed in May 2015 before the children's ward refurbishment.
- The September 2015 infection prevention and control training showed staff who had completed was 78%.

Environment and equipment

- The environment leading to the children's ward was clean and clear of clutter.
- The environment within Jack's Place was recently refurbished (following service users engagement) and was inspirationalin what was offered for children and young peoples service.
- However,the inspectors found the schoolroom had been reassigned to the administration staff for the community services with no alternative area identified for a schoolroom..
- The neonatal unit was a secured entrance and staff were seen challenging visitors to the area.
- The environment within the NICU had not been refurbished for several years and looked tired.
- The mother's expressing room on NICU was an area of limited space and had no facilities for cold drinks.
- The equipment we examined in the NICU, including the resuscitation equipment was serviced, tested and clean as well as dated.
- The NICU parents room had no facilities for making hot drinks or snacks. We were informed that this was a problem when parents stopped on the NICU for long periods to care for their baby(ies).
- We saw different resuscitation equipment in Jack's Place, Chaucer and the accident and emergency department. All had been recently reviewed but we noted that each area within this service had resuscitation equipment from different manufacturers.Staff informed us that they that they had received training to use the equipment within their area.
- There was a padlocked electro biomedical engineering (EBME) room which was an identified storage area for equipment requiring repair.
- Equipment including blood gas analysers, monitors and ventilators had been tested for electrical safety and passed all inspections as safe.
- One secured side room on Jack's Place had been out of use since June 2015 and we were informed that this was due to an outstanding order for parts.
- We examined saturation probes and found that when non disposable probes were used, they were cleaned. Single use probes were disposed of correctly in line with decontamination procedures.

- All equipment was found to be clean and where required, an electrical safety test was completed and dated.
- All equipment we saw had a date of completion within the last six months for the electrical safety test.
- Equipment was stored in a padlocked room on Jack's Place.
- The resuscitation equipment was secured and checked daily with clear recordings of each check.
- The resuscitation equipment across this service was child specific but not consistent across ward and outpatient areas. We saw two different types of resuscitation bags from different manufactures.

Medicines

- Within the children's service there was a dedicated pharmacist who visited daily and who staff reported to.
- We undertook a check of controlled drugs on the NICU and children's ward. Controlled drugs were checked and accounted for in accordance with trust policy including correct storage.
- We examined six records of six children on Jack's Place and six neonates on NICU which included the records of medication administration. Medicines had been administrated as prescribed by the medical team.
- There was evidence of a full medical history being taken, allergy status recorded and where appropriate allergy alert bracelets were used. However one record for child's allergy was not completed of the six records examined.
- We saw ten incidents reported where medication error had occurred but no lessons learned or shared outside of this directorate completed on the evidence provided from the trust.

Records

- Children had risk assessments on admission, which were evidenced in the patient records. 12 patient records were reviewed and all admission assessments were found to be complete. We examined the risk assessments required in both NICU and Jack's Place and found they had been completed by staff.
- Care plans were updated and included pain scores.
- We looked at six sets of medical and nursing records for children and four sets of neonatal records and found completed well organised records. There were two medical signatures that were not legible and we saw no printed surname or grade with that signature.
- We saw from October 2014a presentation to staff of record keeping within this service. Areas of concern found from this audit included, writing clear treatment plans,consultant review within 24 hours of admission, signing and dating adjustments in drug charts,date and times, hospital numbers on each page and bleep numbers by signatures with staff grade. There was an action plan of progress against improvements which we saw during the review of records.
- We were informed that GP discharge letters were sent out electronically but with the recent introduction of Systmone, senior staff confirmed that they had not yet received training.
- A COSHH folder examined contained out of date assessments. The trust had reviewed this process but senior staff were unable to describe their responsibilities following this change, with the withdrawal of the information technology system called Sybol

Safeguarding

- The safeguarding children's policy is currently under review and the existing out of date policy was seen as a printed hardcopy across theservice.We were not assured that staff were using the latest policy.
- The acute safeguarding groups report into the women and children's health directorate and shared with other directorates as appropriate.
- The trust had a safeguarding children strategic group, which reported to the Trust Board.
- Monthly safeguarding meetings and a quarterly operational meeting took place in sub-divisions. Information from these was shared with the Clinical Performance and Patient Experience Committee. Child Sexual Exploitation and Female Genital Mutilation were amongst the areas covered by the strategic group.
- We reviewed the first quarterly report for Safeguarding Children, which related to the period April 2015 to June 2015. Information included for example; review of child deaths, (none at Northwick Park Hospital for the quarter), priority areas of work, training figures and governance and accountabilities.
- Safeguarding supervision was well established within the organisation. All paediatric nurses were able to access one to one supervision monthly.

- Staff we spoke with described the referral process and knew the names of the safeguarding doctor and lead nurse.
- The information technology patient system did not flag up any at risk children or children admitted across the hospital.Senior staff confirmed that admissions were physically sought through effective liaison with the site management team.
- Child protection issues were discussed at staff handover and with the wider team.
- Safeguarding training for staff was 68% at level three, 60% had received the training for level two and 97% of staff had been trained at level one as evidenced in the safeguarding children's annual report. The trust target was for 95% compliance, which meant only level one training met this target.
- Between April 2014 and March 2015, the service had undertaken 376 children's safeguarding consultations for child protection. The total number of safeguarding children cases reported to Datix since June 2015 was 43.
- Within outpatient services, 89% of staff had received safeguarding training at level three.
- We saw no electronical flagging system in place to identify young people admitted to adult beds and no supporting transitional care policy.

Mandatory training

- All nursing staff within the children's services had access to education learning management system (ELMs) where mandatory and additional training could be requested and recorded.
- The trust target for attending mandatory training is 95% with 85% of staff from children's services achieving this at the time of the inspection.
- Accident and emergency department at this hospital had recently reviewed their training needs analysis which had resulted in a percentage reduction of compliance with training for August 2015 to 74% .
- Staff were trained in paediatric life support and neonatal life support with 100% compliance for all nursing staff.
- The registered nurse's extended role included the intravenous training of which 80% of staff have completed this training.

Assessing and responding to patient risk

- The paediatric early warning tool (PEWS) and neonatal early warning tool were seen on all records reviewed. This is a monitoring system to alert staff to the potential risks that a child's clinical condition had changed.
- All records were completed correctly except for one record which had no total score on two entries..
- Management of the deteriorating patients was seen in notes examined with appropriate intervention and timely escalation recorded.
- Staff attended advanced paediatric and neonatal life support training with 80% compliance across this service.

Nursing staffing

- All children nursing staff had (RSCN) qualification and neonatal registered staff had the neonatal course except for three registered staff.
- Nursing staff requirements and actual numbers were on display across all this service areas. Staffing on the children's ward was below establishment.The nursing and healthcare staff establishment on Jack's Place was 42.56 WTE, with actual staff in post 39.5 WTEthere was no current vacancies for support staff.
- The acuity and dependency of patients on the wards were checked twice daily to ensure that staff cover met the needs of the children. When staff sickness led to numbers falling below the required skill mix level, staff reported levels to the operational team to agree bank staff replacements.
- Bank staff used in this service were mostly substantive staff from the children and young people's service. This meant that bank staff used were familiar with the children's areas and had the correct clinical competencies.
- Agency staff had not been employed within the children's ward for the past two years and staff coveredextra shifts by working bank hours. This was except in the case of Jack'sPlacewhere agency staff had been employed.
- We examined the staff electronic roster and saw that shifts were covered by permanent staff members resulting in overtime hours above what was expected for senior staff members.
- There was a sickness rate of 3.4% in nursing, meaning that some shifts had one registered nurse less than required for the patient acuity if bank staff were not obtained.

Services for children and young people

- Handovers seen were structured, comprehensive and outlined the anticipated concerns of that day.
- All bank staff outside of the children's service received a local induction and competency check on the ward.

Medical staffing

- The trust has a lower percentage of consultants and juniors compared to the England average. There were a total of 31 whole time equivalent (WTE) medical staff working in the service, including consultants.
- There were 15 consultants working across this trust of which six were part-time. There were two academic consultants who do not cover on-call rosters.
- There was no specialist or associate speciality grade (SAS) but one trust fellow who was a registrar.
- There were two foundation year one doctors, one foundation year two doctor, one general practitionertraineeand four paedriatic senior house officer (SHO) trainees
- This meant that there were sufficient numbers of staff to provide a safe children and young people's service.
- The consultants were available on site Monday to Friday with out of hours cover (weekend and nights) covered by an on-call rotafor weekends.
- We observed a handover on the children's ward which was well organised, comprehensive and anticipated the issues for the ward area. We saw the multidisciplinary handover between professionals and ward rounds where nursing staff were involved.

Major incident awareness and training

- The major incident policy was available for all staff on the trust's intranet site and staff were able to access this for us during the inspection.
- The major incident plan was last reviewed in January 2015 with senior staff confirming that they had participated in a tabletop exercise.
- However, the staff knowledge base of the major incident plan and business continuity was variable. Three staff spoken with had no awareness and six staff spoken with had someof knowledge. This meant that there was a risk staff actions would be inconsistent in the event of a major incident.
- There was a similar response from neonatal staff who were aware of the major incident plan and their understanding of responsibilities. Staff were aware how to evacuate the babies and we saw the fire evacuation plan

Are services for children and young people effective?

Requires improvement

The children and young people's service for effective was rated as requires improvement.Care and treatment mostly reflected current evidence-based guidance, standards and best practice but out of date policies were seen as hard copies.

We saw no policy for transition from child to adult care.

We identified gaps in the management for supporting children in adult beds with no flagging system to show admissions for young people in adult bedswhich meant care pathways were at risk of notbeing followed.

Outcomes for children who used services were in line with expected ranges, with the exception of epilepsy care, which required improvements e.g. patient and parent information following first fit and the accident and emergency setting.

We found handover on the children's ward comprehensive and were told that a multidisciplinary handover was piloted within the service from April 2015.

Staff in the children's ward and neonatal intensive care unit were qualified although three staff on the neonatal unit had not completed the additional neonatal training programme. This meant that the staff had the skills they needed to carry out their roles effectively and in line with best practice.

There was participation in relevant national and local audits. This service recently participated in the national clinical audit for the initial management of the fitting child. The Royal College of Emergency Medicine (RCEM) standards were met except for standard four, in which 0% was given (there was no written information from the child or parents).

Staff are supported to deliver effective care and treatment, including through supervision and appraisal.

Consent to care and treatment was obtained in line with legislation and guidance. Staff were able to demonstrate a good understanding of the Gillick competence and children were supported to make decisions where appropriate. Parents were also supported to make decisions where

appropriate and offered information to make best interest decisions for their child in respect of treatment. The Gillick competence is a test in medical law to decide whether a child of 16 or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge.

Evidence-based care and treatment

- Care was provided to children and young people in accordance with national guidance. Policies were based on National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics guidelines.
- Staff had access to guidance, policies and procedures on the trust intranet. However, we could not confirm the adherence to local policies and procedures across children's service as we saw a folder containing twelve out of datetrust wide and children's service policies. These included safe handling and disposal of sharps, prevention of infection in central venous access catheters, prevention of infection in peripheral venous devices, organisation wide infection prevention,blood cultures, aseptic techniques, management and control of diarrhoea and vomiting, terminal cleaning guidelines and waste management policy.
- There was evidence of local audit activity e.g. cleanliness audit and record keeping with National audit participation in Diabetes in paediatrics.
- The risk of abduction policy was in draft form which was discussed at the last senior nurse meeting in September 2015.

Pain relief

- We examined the records of patients across children's service and observed a child specific pain monitoring score. Pain scores were recorded which were then monitored by staff during observational care rounds. Further pain relief was offered as required and prescribed.
- We examined the records of five neonates on the NICU and observed a neonatal specific pain monitoring tool which was completed and monitored appropriately in all five records.
- We spoke with six children and their parents. All confirmed that pain relief was managed and monitored to promote successful pain management. None of the children or parents raised any concerns about pain relief or pain monitoring. .
- Staff confirmed that they had no difficulties when requesting further pain relief prescriptions for children.
- We saw the diversional therapy used for children and young people, which was led by the play specialist.

Nutrition and hydration

- On the neonatal unit, staff weighed neonates regularly in line with requirements to enable accuracy in calculation of daily fluids which assists nutritional feeding support
- Fluids offered were documented on the children's fluid input chart.
- Weights of children were monitored with clear care plans of how the service would meet the needs of the child.
- We spoke with staff and parents who stated that children did not like the hospital food offered.
- We saw a Steamplicity children's food menu which gave children a choice but parents told us they were encouraged to bring in food for their children.
- Dietician support was accessed as required but was in the therapy service not within this service. The dietician recorded in the children's notes with reviews updated as completed
- The patient led assessment in a clinical environment (PLACE) was scored at 92% for food, which is above the England average of 90%.
- Fridges used across the service for food storage were checked daily and if the temperature was outside the expected limits actions were taken and recorded.

Patient outcomes

- The CQC reviews the information provided by trusts to assess if the service has a higher mortality rate for patients with different conditions. These are called outliers if they are outside of the national rates. There are no open CQC Outliers for this service.
- The number of elective admissions were 28% for children in the under one age group and 72% in the 1 to 17 age group and both had a length of stay of less than a day. This meant that the trust's median length of stay for children for non-electiveand elective stays wasbetterthan the England average for children under one year andfor children aged 1 to 17. The median length of stay being 1-2 days.
- The rate of multiple emergency admissions within 12 months for asthma, epilepsy and diabetes was slightly better than the England average.

Services for children and young people

- The emergency readmission rates within 2 days of discharge was worse than the England average for non-elective and elective admissions.
- The multiple admission rate for children was higher than the England average of 17.4%.
- The proportion with diabetes (HbA1c)lower than 7.5%, is lower than the England average. Median HbA1c levels for patients are higher.
- This hospital recently participated in the national clinical audit for "the initial management of the fitting child". The Royal College of Emergency Medicine (RCEM) standards were met except for standard four in which 0% was given as there was no written information for the child or parents.
- The trust scored about the same as other trusts in the 2014 children's survey regardingsafety,the only exception being the lower score received for cleanliness.
- The trust scored about the same as other trusts in the 2014 children's survey regardingeffectiveness.
- The median length of stay was mixed with one indicator below the England average, one above the England average and two the same (June 2015).
- Paediatric asthma audits performance had been developed this year in line with the commissioners and an agreed commissioning for quality and innovation(CQUIN)scheme was seen to reduce the proportion of avoidable emergency admissions to hospital, which improves care for children with asthma. This project will develop community led specialist services for children with asthma and is supported by acute clinicians and expert general practitioners. The programme is on track to meet quarter one requirements. This programme has included setting up educational programmes for staff, children and parent with support of asthma specialist nurse in accident and emergency department. .
- Paediatric diabetes audit performance report was requested but not received
- The record keeping audit submittedby the trust showed that 48% of patients were not seen by a consultant within the first 24 hours following admission.This data is currently not comparable through the CQC analysts.

Competent staff

- Across children's services, 85% of staff had received an appraisal within the last year. We spoke with senior staff who confirmed there was a clear plan to complete the remaining staff appraisals except for those who remained on maternity or sick leave.
- Supervisory sessions were held with staff but we were not assured that thesewere prioritised with the current usage of ward staff completing extra bank shifts although staff spoken to confirmed that they had received supervision.
- Throughout this service, revalidation for nursing staff in line with Nursing and Midwifery Council requirements was supported by senior staff.
- Staff had received or were booked on an update training date for paediatric or neonatal life system.
- Revalidation for all medical staff had been undertaken for 100% of medical staff. The clinical director confirmed that dates had been set for any outstanding appraisals.
- We saw that staff were working bank shifts in addition to their own shifts to avoid the use of agency staff. Agency staff had not been used across this service for 24 months.

Multidisciplinary working

- We observed that staff across this service worked effectively together and with the children's community services.
- We observed the handover of the care of a neonate with multidisciplinary discussions and care pathways completed. The communications observed between doctor and nurse were professional and followed the effective structured method for communicating critical information (SBAR)approach.
- Staff we spoke to confirmed there were good working relationships between themselves and other professionals.
- We reviewed a presentation from a study day promoting the work of the transition to adult services. We were informed that there was no flagging system to identify any children or young person admitted to an adult ward. The trust had no policy for the transition of children into adult services. However, senior staff spoke regularly with the operational site team to confirm young people admissions to adult beds

Services for children and young people

- Access to psychiatric and psychology services was available through the child and adolescent mental health services (CAMHS). We were informed of examples of when these services had been used and staff reported a good working relationship with these teams.

Seven-day services

- The NICU and children's services had consultant ward rounds seven days a week and the consultants were available outside of normal working hours through the on-call weekend rota and on call system.
- The pharmacy department was open Monday to Friday, with on-call arrangements for weekends and outside normal hours on weekdays.
- The support services for this service e.g. imaging services, occupational therapy and physiotherapy were available Monday to Friday, with out of hours arrangements supported by an on call system.
- The trust wide spiritual care and chaplaincy team were available for pastoral support for children their families and staff. This service was available 24 hours a day, 7 days a week via an on call system.

Access to information

- Staff in the accident and emergency department for children do not have access to the information technology patient flow system called Symphony which is available at Ealing. This meant they was not an integrated system.
- Policies and procedures were available for staff to access through the intranet system. There were hard copies of policies found in the Chaucer unit and children's outpatient department at this hospital.
- Staff had access to all main computers, including test results, diagnostics and patient record systems. There were sufficient computer points across the service to support staff.
- Discharge letters were sent to general practitioners but were not always received in a timely manner.

Consent

- All the staff we spoke with were aware of Gillick competence. This is a decision whether a child of 16 years or younger is able to consent to his/her own medical treatment without the need for parental permission or knowledge.
- Staff articulated the requirements of Gillick competence and informed us that they encouraged the child or young person to be part of the decision making process in relation to their care.
- Parents were also supported to make decisions where appropriate and offered information to make best interest decisions for their child in respect of treatment.
- Parents were seen to be involved in the decision-making processes regarding care. Leaflets were available for parents who were making decisions about providing consent to surgery.
- The six consent forms reviewed in the patient records were completed, dated and had legible signatures.

Are services for children and young people caring?

Good

The services for children and young people and the neonatal intensive care unit are rated as good.

Family members and children we spoke with during the inspection were all positive about the care provided and the parents believed that the staff were dedicated and professional when caring for their child. They told usthey were able to ask if they were unsure of anything .

We observed staff interactions with children and families which were positive. All parents and children confirmed that the nurses were polite, professional, helpful and friendly. Staff showed respect protecting children and young people's dignity and privacy across the service. Children seemed to get on well, with staff members observed explaining everything to them.

Children and their parents were included in the planning of care. Children were encouraged and supported to make decisions regarding their care, which was explained in a manner that was understood by the child.

The children's survey, undertaken by the CQC in 2014, showed that the trust performance was about the same as other trusts of a similar size for feedback from children.

Children and their parent's emotional needs were also recognised with support from specialist staff, chaplaincy and counselling services available.

Services for children and young people

Staff responded compassionately when children or their families needed help and supported them in accessing the correct pathway for individualised care.

Compassionate care

- Friends and Family test results show thatthe scoreis better than the England average. Friends and Family test results seen for October 2015 showed all areas within children and young people achieved 100% from parents and children recommending this service.
- Inpatient survey results seen forSeptember 2015 showed that 87% of the 15 children and young people completing the audit for Jack's Place recommended this department to friends and family if they needed similar care or treatment.
- Patient led assessment of the care environment (PLACE) showed that this hospital came out much worse than average privacy and dignity and wellbeing when compared to the England average.
- We observed all areas of the children and young people's service, listened to groups of staff and individuals who were involved in patient care and found that staff responded appropriately and supported them to meet their needs.
- We saw good interactions between staff, children and families when staff checked to ensure the children and parent understood the doctors reason for changing medication.
- All parents we spoke with during the inspection told us that they had been treated with respect and dignity by the staff. This included one mother who was breast feeding her baby so her older child was admitted to a side room.
- Two set of parents spoken to within the service had no concerns or complaints and described staff as supportive. " If I have a problem they seem to anticipate it before I even have chance to tell them".
- The CQC undertook a children's survey in 2014. We asked children and young people and their parents and carers, to answer questions about different aspects of their care and treatment. The trust scored about the same as other trusts in relation to C1. "Are people treated with kindness, dignity, respect and compassion while they receive care and treatment"?
- We saw patient feedback information on the care of children and young people through the NHS Choices patient forum. Comments were mostly positive but,there was no acknowledgement from this hospital
- The service had received no complaints over the past twelve months but had received numerous compliments.
- Thank you cards were seen on the boards in ward areas and staff described informal thanks had been received from grateful families.

Understanding and involvement of patients and those close to them

- The play specialists in this service were good and demonstrated how they could make a difference to the service and its environment in meeting the needs of the children and young people
- We observed staff explaining to children procedures and what children were going to have done to them in away that the child understood. They spoke to children in a calming and support manner.
- Parents we spoke with told us that they were informed about their careand could ask any questions of the doctors or nurses. " My husband and I recognise the lengths the staff go to, to support her when she is stressed on one of her many admission. They are part of our extended family".

Emotional support

- Staff gave examples of how they were able to access support and training they received for breaking bad news.
- Clinical nurses for children specialities including oncology and learning disabilities supported staff, children and families when required.
- The Play specialist created lots of opportunities for the children to receive diversional therapy whilst in, or waiting for a hospital service.
- Assessments for anxiety were completed as part of the admission process within this service.
- The trust counselling services could be accessed as requested during the working week Monday to Friday.
- The trust wide spiritual care and chaplaincy team were available for pastoral support for children and their families and staff. This was available 24 hours a day via an on-call system.
- Schwartz rounds commenced in the trust 8 months ago senior staff from this service had attended. Schwartz rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. There was no evidence of paediatric cases discussed.

Services for children and young people

Are services for children and young people responsive?

Good

We ratedresponsiveness for thechildren and young people's serviceas good.

The facilities available to families enabled them to stay and met their needs when supporting their children. The children had indoor play areas but no schoolroom. Although a room outside of Jack's Place remained labelled as schoolroom, this was now accommodating the children's community administration team.

Inpatient services were planned and delivered in a way that met the needs of the children and young people of the local population. Care and treatment was mostly co-ordinated with other services and other providers including other specialist children's services and hospitals, school nurses, health visitors and mental health services.

Children can access care when needed. Admission rates were higher than the national average for emergency admissions.

It was easy for parents and families to complain or raise a concern. Staff described how they could treat any complaint as a learning opportunity and families were treated compassionately when they did. There were no complaints in the past year but ?

The service had responded to the needs of families with arrangements to meet the diverse language needs of the population served by this hospital. There were leaflets for families in a variety of languages and staff were able to identify how to access a translator, with staff identified across the trust where English is not the first language.

The service was achieving 93% of patients being seen within 18 week of referral for treatment.

Service planning and delivery to meet the needs of local people

- here were a number of specialist staff to support children and young people within this service
- There was a promotion of out of hospital care across the service. We were informed of a shift of outpatient delivery to non-hospital premises with a review and reduction of accepted outpatient referrals.
- Senior staff discussed the introduction of the'3 hub model' of paediatric services which focused on the planned, emergency and community services for children..
- . Parents we spoke with told us that staff would make drinks if they asked for them. This was not mentioned in the NICU leaflet given to parents.
- There was a range of leaflets and posters available in the ward and clinic areas. The NICU welcome leaflet was photocopied and was not dated or seen in another language other than English
- We saw DVDs and electronic games as well as board games to meet the varied needs of this service.
- There were plenty of clean toys, books and other items for children to use during their stay in hospital
- The merger with Ealing had provided an opportunity for children and young people's services to be reconfigured. There was evidence seen of some integrated working between staff but we saw areas which remained working separately even after twelve months. This includes different coloured uniforms worn by senior staff, the ' Your stay' patient leaflet which was due for review in 2013 and outdated policies printed and available within the children's Chaucer area and outpatient area
- Staff described information technology systems that were not compatible with Ealing Hospital or the community system.
- **Access and flow**
- Bed occupancy for Jack's Place was regularly above 85% but was below that bed occupancy during our inspection. Research shows that if bed occupancy is above 85%, the risk of care becoming compromised is higher.
- Children who attended the hospital in an emergency were seen in the children's accident and emergency department. When identified as requiring admission, the child or young person was admitted to the children's ward as soon as a bed was available. A clear escalation plan prevented delayed admissions breaching 12 hour waits through communication with senior managers.

Services for children and young people

- If the young person was admitted to an adult bed, the system to highlight this admission to this service was through senior staff communicating with the operational site team.
- We saw the patient flow escalation plans for children's accident and emergency department to reduce waiting times, with two hourly board rounds completed and escalation to ward staff to support the department.
- The service was achieving 93% of patients being seen within 18 week of referral for treatment.
- Admission processes for Chaucer were described by staff: Senior staff informed inspectors that patients were planned and booked but emergency patients were sent from accident and emergency unannounced which caused longer waiting times within the department.
- There is a open door policy for oncology children within Chaucer unit which is good for those children. The unplanned appointments gave additional support for children and their parents but created longer waiting times for other children with planned appointments. The parents spoken to appreciated that the priority was a child that needed a review over a routine appointment.
- The Neonatal Intensive Care Unit capacity was achieved with opening extra cots.

Meeting people's individual needs

- The service had access to a 24-hour translation service through "language line" and in-house interpreters. Staff were aware how to access this service when required.
- Child and adolescent mental health services were available through the local mental health trust. We were informed that this service would respond to the needs of the child and worked well.
- There is specialist support for caring for children with complex needs and this includes: diabetes, asthma and epilepsy.
- We found posters across the service in English but none in other languages, although leaflets were available in several languages.
- There was a schoolroom which was used as the children's community administration office.
- There was an identified clinical nurse specialist for learning disabilities and staff were aware how to access additional resources e.g. loop system or audio books.
- The play specialist supported staff working with the team to support children and young people.
- Within Jack's Place ward area, there was a secure indoor play area.
- There was an area for adolescents within the ward, which would meet the needs of the individual with sofa, game consoles and a television.
- One parent of a child was able to stay overnight on the ward as outlined in the ward information leaflet for Jack's Place.
- Side rooms where private conversations could take place away from the main ward environment to ensure privacy was maintained where available.
- We were informed that one side room was not used as the service was waiting for parts to arrive. This room was closed from June 2015.

Learning from complaints and concerns

- The trust provided a 'listening, responding and improving your experience' leaflet which was seen in a variety of languages. This leaflet details the patient advocacy and liaison service (PALS)
- How to make a complaint leaflet was seen across the service but only in English but on the last page of the leaflet, it does refer to the availability of the leaflet in other languages, large print, audio or Braille.
- Between March and October 2015 there were 23 complaints for this service which were all closed. Senior staff confirmed that they were anticipating the parents needs and dealing with concerns before they became complaints.
- Posters and leaflets were displayed across the area informing parents how to make a complaint.
- Any complaints received were displayed on the ward safety board, which was situated at the entrance of the ward and showed no complaints for this year. The board also included a 'you said, we did', which demonstrated how the staff listen to the feedback from the Friends and Family Test or complaints.

Are services for children and young people well-led?

Good

The servicewas rated as goodfor well-led.

We were informed of a strategy for future changes within the service.

Services for children and young people

All staff spoken with were aware that the trust values and philosophy of the service which was to provide safe, high quality patient care centred for children and young people through integrated care across community and acute settings.

There was a good level of staff satisfaction within this service and staff spoke about providing the best care possible for the children.

Staff engagement was supported through team meetings, feedback and staff surveys.

Governance arrangements were developed and performance monitored.The children and young people's service risk register was in use and monitored monthly at the service risk meeting covering clinical quality of care, governance, capital resourcing, estates, workforce and strategic change and finance..

The children's senior staff communicated well with staff across the hospital sites. Children's experiences were seen as the main priority but systems did not support children nursed outside of this environment e.g. adolescents nursed in adult wards was not flagged up through information technology systems.

Staff engagement was supported through team meetings, feedback and staff surveys.

Vision and strategy for this service•

- Staff confirmed that they were aware of the local strategy but not all staff could confirm awareness of the trust wide strategy.
- All staff spoken with were aware that the trust values and philosophy of the service which was to provide safe, high quality patient care centred for children and young people through integrated care across community and acute settings
- Senior staff explained the development of the paediatric strategy to centralise this service but not all staff spoken to were aware of local plans.

Governance, risk management and quality measurement

- The children and young people's service risk register was in use and monitored monthly at the service risk meeting.
- The children's directorate risk register was reviewed and was found to identify risks related to; clinical quality of care, governance, capital resourcing, estates, workforce and strategic change and finance. Risks were scored from initial rating to a target rating and the current rating. A colour code was applied to indicate level of risk, using green, amber up to a red risk rating.
- The children's service fed into the hospital governance committee by providing their own governance report.
- There was evidence of incident reporting and audit, with identified themes or trends but saw no supportive data included for lessons learned
- Governance arrangements were developed and performance monitored but there were identified areas that were not addressed. We saw out of date leaflets, policies and spoke to senior staff who told us of the high vacancy levels within therapy services which impacted on the support available for children's services.
- We found risk issues which were not dealt with in a timely way. We saw the risk register within the recovery area for children in theatre which was not children focused and had no improvement plan.
- The service had a children's dashboard which was completed and available for everyone to review as well as directorate and ward meetings to evaluate performance.
- Ward meetings were held monthly and we saw minutes that included risks and areas to improve patient safety which was escalated through the matrons to the senior team.
- Local audit activity to measure the quality of children's health services was undertaken and infection control audits and record keeping audits were reviewed.
- We saw a good example of learning lessons in a neonatology leaflet for staff.
- The service had a newsletter known as 'risk news' which provided staff with shared learning from incidents on a monthly basis

Leadership of service

- Staff told us that the senior team were visible and approachable. Staffreported beingsupported and engaged more in the last year.
- Multidisciplinary meetings were well attended and everyone had an opportunity to speak and were listened to

Services for children and young people

- The major incident plan had been reviewed in January 2015 but staff had not been involved in any practical exercises. Senior staff told us that the recent table top exercise had included a children's service representative.
- Of the ward staff spoken with, only two were able to name the executive board member who represented this service.

Culture within the service

- Staff described the culture as being open and supportive.
- Junior doctors spoken with confirmed that consultants were supportive and that they had a structured training programme.
- We saw good multidisciplinary working with everyone putting the children and young people and their families as the priority.
- Staff were willing to speak to inspectors throughout this inspection and were passionate about the care they gave children and their families.
- Staff were given opportunities to develop and were motivated and enthusiastic.

Public and staff engagement

- Friends and Family Tests were used and results displayed showed 100% that children and parents would recommend this service.
- Parents confirmed that they were involved in all aspects of their child's care and given information when required.
- Children were encouraged to share their experience throughout the sessions with the play specialist.
- Jack's Place refurbishment was completed on the Friday prior to the week of inspection but staff confirmed there was a grand opening event planned which would involve all parents and children.
- Staff reported positively on their level of engagement with managers in this service.
- Staff we spoke with informed us that they had development opportunities and gave examples where they had progressed through the service.

• Overseas nurses were supported to develop at this trust. The trust was working with a local university to support overseas nurses with additional qualifications so that they progress in their careers.

• Three student nurses stated that they wanted to work at this trust when they completed their studies and were qualified, due to the support received whilst on placement.

Innovation, improvement and sustainability

- Jack's Place was recently refurbished based on an idea following staff and children and young people's feedback. The ward's castle like features and dungeon door to the matron's office appeals to all across this client group.
- Senior staff informed us of the trust introducing the Schwartz rounds with representation from this service. Schwartz rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work.
- We were informed about the introduction of the GP paediatric support service to reduce avoidable admissions.
- We saw evidence of the project 'Itchy, Wheezy, Sneezy' a CQUIN agreed with the commissioners.
- We were informed about the use of optiflow to support high dependency cases (HDU) cases on non-high dependency wards.
- **We saw staff from this service were nominated for local and national awards.**
- Therapy staff had received national recognition for supporting the development of the competencies for speech and language.
- The shaping a healthier future (SaHF) programme to eventually remove Ealing Hospital children's inpatient and children's emergency department had led to innovations within this site to accommodate increased capacity.

End of life care

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

Information about the service

End of life care (EOLC) refers to patients who have been identified as having entered the last 12 months of their life or less. It refers to health care, not only of patients in the final hours or days of their lives, but more broadly the care of all those with a terminal illness or terminal disease condition that has become advanced, progressive and incurable

Palliative care is amultidisciplinary approach to specialised medical care for people with serious illnesses. It focuses on providing patients with relief from the symptoms, pain, physical stress and mental stress of a serious illness, whatever the diagnosis is (therefore cancer or non-cancer). The goal is to improve quality of life for both the patient and the family. Palliative care can be provided along with curative and non-curative treatment and is appropriate at any age and at any stage in a serious illness.

Palliative care is provided by a specially trained team of doctors, nurses and other specialists who work together with a patient's other doctors to provide an extra layer of support. It is appropriate at any age and at any stage in a serious illness and can be provided along with curative treatment.

The specialist palliative care team (SPCT) for Northwick Park and St Mark's Hospital is based in the Macmillan Unit at St Mark's Hospital. The team is made up of specialist palliative care nurses(SPCNs) and consultants. The SPCT provided specialist support for people facing serious illness which was usually complex. Patients who did not have complex serious illness or potentially complicated deaths were supported by other generalist or speciality doctors and nurses on the ward the patient was admitted to; the SPCT was available to give support and guidance to staff about these patients if they required it. During the period 1 January to 1 October 2015 there were 955 patientsreferred to the SPCT of which 61% had a cancer diagnosis and 39% had a non-cancer diagnosis.

The hospital does not have any dedicated beds for patients who are approaching the end of their life. Patients were cared for in a side room on the main wards where possible. The SPCT worked closely with the patients and those close to them, the hospital doctors, ward nurses and other professionals in supporting the patient's needs. They also liaised with hospices and other community support agencies.

The SPCT was available Monday to Friday from 8am to 4.45pm and out of hours; on-call cover was available to clinicians.

During this inspection, we spoke with 17 members of staff; which included local level service leads for specialist palliative care and end of life care, ward nurses, allied health professionals, clinical nurse specialists in palliative care and consultants, administration staff, porters, staff in the bereavement office and mortuary anda chaplain.

We spoke with two patients and five relatives. We reviewed four care records and four do not attempt cardio pulmonary resuscitation (DNACPR)records. We also reviewed thank you cards and letters. During and prior to the inspection we requested a large amount of data in relation to the service which we also reviewed.

End of life care

We visited the mortuary, multi-faith room and some wards at Northwick Park Hospital.

Summary of findings

We rated the end of life care services at Northwick Park as 'good' overall. We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner.

The patients and relatives spoke positively about their interactions with the teams involved in their care. They described the staff as "very busy but very kind" and that "they do all they can". They told us theywere able to raise any concerns they had. The trust had responded to the withdrawal of the Liverpool Care Pathway, which had previously been seen as best practice when someone reached the last days and, hours of life. The trust used a holistic document which was in line with the five priorities of care. This care plan, called the 'Last Days of Life Care Agreement' (LDLCA), guided staff to consider and discuss the patient's physical, emotional, spiritual, psychological and social needs. The LDLCA also took into account the views of those important to the patient and provided them with an information leaflet about what happens when someone is dying, and what to expect. Relatives spoke positively about this as it gave them confidence to know what to expect and how they could support their family member. This document was not compulsory to use across the hospital and we found where it was not used, that it was difficult to navigate the proposed care planor gain a clear understanding of the patient's wishes and needs.

As part of the LDLCA the patient's pain relief, symptom management and nutrition and hydration needs were monitored and recorded at regular intervals during the day. Patients' records and care plans were regularly updated, matched the needs of the patient and were relevant to EOLC. The LDLCA reminded staff that they should remain open to the possibility of changing the plan should a patient's clinical condition change. This included withdrawing the LDLCA if the patients did not deteriorate at the expected rate and therefore it wasno longer appropriate for it to be used.

There were some concerns raised by specialist staff and from our observations about whether all generalist nurses, doctors and consultants had the expertise to recognise dying; and had the skills to have difficult

End of life care

conversations about planning care for those at the end of their life. We were given examples of patients' treatment and observations continuing when EOL had been identified. This could cause the patient unnecessary pain and discomfort at a time when these actions would make no difference to the patient's health and wellbeing. We saw that staff considered cultural differences when discussing death and dying and only took the conversations as far as the family were comfortable. However less experienced staff could use this as a reason not to discuss a patient's prognosis which meant some patients and families may not know what resourceswere available to them at the end of life.

The SPCT were focussed on raising staff awareness around EOLC. However they said that this should be a trust wide responsibility as "death and dying is everyone's business" and the onus should not be placed solely on the SPCT to take forward. The trust had recently run a pilot training scheme for staff on the elderly care wards. The training was well received and the resulting recommendation was that EOLC teaching should be made available to everyone as part of their mandatory training. The trust had recently secured funding to develop an e-learning package. However staff had expressed a concern about engaging doctors, consultants and other staff being given time to take the training if it was not made compulsory.

Staff were aware of their responsibility in raising concerns and reporting incidents. We were given examples of incident and the resulting actions and learning from them. Staff were keen to report any incidents in relation to palliative and EOLC in order to drive improvement and ensure the same mistakes were not being made. There were few complaints in relation to EOLC and staff told us they preferred to deal with concerns or issues at the time to try to deal with it prior to it becoming a formal complaint. However if the patient or family was not happy with this they would support them in making a formal complaint through the correct channels.

Staff were able to explain their understanding of the Mental Capacity Act (MCA) 2005 and Deprivations of Liberty Safeguards (DoLS). They told us they would act in the best interests of the patient should they lack mental capacity to make decisions for themselves. They understood the patient's carer should be consulted in gaining an understanding of what the patient would want when making best interest decisions and people could not consent on behalf of the patient unless they had a relevant legal directive to do so. All staff understood their role and responsibility to raise any safeguarding concerns.

We found that leadership of the SPCT was good at a local level, and all staff reported being supportedby their line managers. Although the specialist staff reported a better emphasis on EOLC at board level over the last year, theyperceivedthey were still the key driver for improving staff engagement, training and skills and, if it was not for their involvement, staff development in EOLC would not remain a priority for the trust.

The SPCT were able to communicate the trust's vision. However they were not always able to explain how this was going to be met. Cross site working was in its infancy and staff expressed a difficulty in doing more due to the difficulties in physically getting between the hospitals in the trust.

End of life care

Are end of life care services safe?

Good

Safety across Northwick Park Hospital for end of life care was good. Openness and transparency about safety was encouraged. Staff fully understood their responsibility to raise their concerns and report incident and near misses. Incidents were investigated adequately and learning points and actions identified. Staff expressed a willingness to learn from them to reduce the risk of them recurring and to improve on standards. The SPCT supported training staff on the wards where any EOL or palliative care incident was identified. We were told that incidents relating to EOLC were discussed in team meetings across the trust and therefore with colleagues at other hospitals within the trust.

There were good arrangements in place to manage patients' medication in the hospital and for patients to take home with them if they were discharged. Syringe drivers were available for appropriate patients and there were no reported difficulties inobtaining them.

Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff were able to communicate their responsibility and role in early identification of any concerns. They knew who the safeguarding lead for the trust was and where to get guidance should they require it.

All staff received mandatory training and the SPCT had achieved 100% compliance in most subjects. Those that were not achieved were due to one member of the team requiring to complete the module. Anyone requiring to complete a module was doing so in the next few weeks. However porters told us that since the service had been procured by a private company they no longer received mandatory training, including safeguarding training. This was contradicted by the trust who subsequently told us that role specific and mandatory trainingwas provided for porters. This includedseven mandatory topics and further role specific training relevant to tasks undertaken e.g. specimen collection.

The SPCT were highly skilled in supporting patients with complex health issues and requiring palliative or EOL support. Patients who came under their care were regularly assessed and any changes documented clearly. However we had some concerns about whether generalist nurses, doctors and consultants always recognised a change or deterioration in a patient that could indicate they were approaching the last 12 months or less of life. This meant that a patient identified as requiring EOLC could continue to receive treatment and observations that were no longer beneficial and could cause unnecessary discomfort for the patient.

We found, where staff used the 'Last Days of Life Care Agreement' document to plan holistic care and support for the dying patient, that the patientrecord was clear. Staff spoke positively about this record as it guided them through everything they should consider and discuss with the patient and those close to them. Where this document was not used we found that records were difficult to navigate as conversations and agreed treatment and care options was scattered throughout the patient's record and did not give a clear picture.

Safety performance, Incident reporting, learning and improvement

- Serious incidents known as 'Never Events' are largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented. End of life care (EoLC) services had not reported any never events or serious incidents in the last 12 months.
- The trust had systems in place to report and record safety incidents, near misses and allegations of abuse, and share any learning and changes to improve the safety and quality of the service. In the period from 1 August 2014 to 31 July 2015, the trust reported 36 incidents relating to the palliative and end of life services across the hospital. One was recorded as major harm that could cause permanent or long-term harm, two were recorded as moderate harm, 22 were recorded as happening but caused no harm, seven as minimal harm, and four as a near miss. The mortuary reported 39 incidents in the same period: one was recorded as minor harm, one as moderate harm and 37 were recorded as happening but caused no harm. The incidents were adequately investigated and a root cause analysis had been completed with learning points identified.

End of life care

- Staff told us they used the electronic reporting system 'Datix' and received feedback from any reports they lodged. The SPCNs we spoke with all told us they had time to report incidents. Senior staff were confident anything of concern was reported, and the SPCNs we spoke with gave us examples of concerns relating to the care of dying patients, which they had seen and as a result reported. All staff in the SPCT told us, if they did not report concerns, themes and rate of occurrence could not be identified and it would be difficult to effect any change in practice or procedures, or identify training needs.
- The Datix system allowed incident reports to be shared between Ealing and Northwick Park Hospitals. There were opportunities at joint meetings to discuss incidents that affected all services across the trust, for example, those that meant a change in policy or procedure. Reminders were displayed on the trust's computer screen savers.
- The SPCT held a weekly multidisciplinary team (MDT) meeting as well as discussing their current caseload they discussed any concerns or incident to maximised learning and improved safety.
- Staff were trained on duty of candour as part of the risk management training at induction and atthe mandatory update training. The staff we spoke with understood their role and responsibility in informing patients of incidents that could or have affected them. They told us they would apologise and explain what action had been taken because of the situation. Staff added they would support a patient in making a formal complaint if they were not satisfied with actions taken. We saw decisions about informing patients of any incident that had or could have affected them was documented in the incident log.

Cleanliness, infection control and hygiene

- We found the trust had systems in place to prevent and protect people from healthcare associated infections. The trust had an infection prevention and control policy (IPC) and all staff received training. The staff we spoke with had a good understanding of IPC practices and we observed staff following IPC measures when visiting the patients on the wards. Staff were aware of patients' reduced immune systems and the measure they should take in order not to compromise their health through poor infection control.
- Infection prevention and control formed one of the mandatory training modules for staff. All the clinical and non-clinical staff in the SPCT had completed this training.
- Most staff adhered to the bare below elbows policy. However we observed a few staff wearing rings with stones in them whichwent against guidance of only wearing a plain band ring.
- At the time of our inspection the mortuary was going through a refurbishment. The area was kept as clean and tidy as possible although it was inevitable that there was some building dust visible where the renovation work was taking place. However we observed this was being kept to a minimum.
- Deceased patients who had an infectious disease were identified by a wristband and placed in a body bag. A high-risk identification sticker was attached to thebag once they arrived at the mortuary, where they were placed in a separate fridge. Any visitors for the deceased were advised not to touch the body and the undertakers were informed for their own protection when they collected the body. However the nature of the infection was not disclosed unless absolutely necessary. Personal protective equipment such as gloves or aprons were provided to undertakers if required.

Environment and equipment

- The trust used T34 syringe drivers which were all of a standardised type that conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia.
- When we last visited the hospital the SPCT held the stock of syringe drivers and the SPCNs delivered them to the ward when they were required. This practice had been stopped to free up the SPCNs time. Each ward was responsible for ordering syringe drivers from the equipment library when they were required. The SPCT reported that there had been some resistance to this

change; however they had found the ward staff now took ownership of the drivers; and due to less reliance on the SPCT there were fewer incidents as nurses set them up more regularly.

- The trust had responsibility for maintaining all the syringe drivers. We were told there were no problems in accessing syringe drivers whenever they were needed for patients.
- The mortuary entrance was discrete. The path to the mortuary area was being refurbished and a covered walkway was being installed.
- Due to the refurbishment of the mortuary the fridges had been relocated to a temporary area while the work took place. The mortuary manager had put in place processes to ensure that the deceased was kept in the best condition as possible. Fridge temperatures were checked daily and any concerns reported immediately. An alarm sounded should the fridge temperatures drop below the required temperature.
- Systems to ensure the correctidentity of the deceased person were in place.
- Equipment such as trolleys, cleaning equipment and personal protective equipment were clean and stored in a tidy manner. No post mortems took place at the hospital. There was a male and female changing room available for the mortuary technician.
- A viewing room provided families or friends a private quiet space should they wish to spend time with the deceased. We found this and the waiting area was clean and tidy. Deceased**c**hildren and babies were laid out in a smaller bed or a Moses basket.

Medicines management

- There were arrangements in place to keep people safe and manage medicines for patients. Medicine management formed one of the mandatory training modules for staff. All the clinical staff in the SPCT had completed this training, some of the SPCNs were able to prescribe EOLC medication, those who were not trained to be in prescribers expressed an interest in completing the course and some were due to start this in 2016.
- As part of the patients' holistic assessment symptom control and medication was monitored and reviewed by a SPCN and any changes were discussed with the consultant responsible for their care and the ward staff. This was documented in the patient record.
- Patients who expressed a wish to die at home were discharged from the acute hospital with anticipatory injectable medication and medication record charts. These were provided to patients whose condition may require the use of injectable medication to control unpleasant symptoms if they were unable to take oral medication due to their deteriorating condition. Having anticipatory drugs available in the home allowed qualified staff to attend and administer drugs which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital.
- Where appropriate patients had syringe drivers which delivered measured doses of drugs over 24 hours. They could be discharged from hospital with a syringe driver in place however this needed to be changed to a syringe driver from the community resources as soon as practicable and the hospital driver returned.
- The syringe drivers were locked as per guidelines to prevent other people altering or increasing doses.
- We noted that medication administration records were completed correctly and signed. We found the prescribers' names were not always clearly printed on the medication administration records although they were always signed, this could make it hard to find the prescriber if anyone needed to discuss the prescribed drugs.
- Specialist palliative pharmacy support was notavailable for staff, however they could get advice and support from the hospital's pharmacist.
- A recent controlled drugs audit and two incidents found that staff tended to recognise and write prescriptions using the brand names as opposed to using the generic names for drugs. For example, the brand name for morphine sulphate IR is Oramorph. We were told on an incident where a nurse refused to administer morphine sulphate, as they did not identify it as Oramorph. Because of this all staff were reminded to prescribe medication as per their generic name. For example morphine sulphate solution and not Oramorph.

Quality of records

- People's individual records were written and managed in a way that kept them safe. Records reviewed were accurate, legible, and up to date and stored securely.

- Patients' palliative care needs, care plan and resuscitation status was entered onto a system called 'Coordinate my Care' (CmC). CmC is a shared clinical service which allows healthcare professionals to record a patient's wishes and ensures their personalised care plan is available for all those who care for them, including ambulance and community services.

Safeguarding

- Staff understood their role with regard to keeping patients' safe and reporting any issues. This included identifying any risks to the patient's family such as children or vulnerable adults whose main carer maybe the patient.
- All staff complete training about safeguarding children and vulnerable adults as part of their mandatory training modules. Staff demonstrated an awareness of safeguarding procedures and how to recognise someone at risk or had been exposed to abuse. Staff told us if they had any concerns they would speak to the trust safeguarding lead or their manager, and knew where to access the trust policy on the intranet.
- Staff safeguarding level one and two training for adults was part of mandatory training and was routinely provided to all staff. Similarly safeguarding children level one training was provided to nearly all staff including administrative and clerical staff. Safeguarding children level two was mandatory for all nurses and allied health professionals. The SPCT had achieved 100% compliance in safeguarding children level one and two; and 100% compliance in safeguarding adults level two, one member of staff was required to complete level one and records showed this had not been completed.
- Portering staff were employed by a private company; the porters we spoke with told us they had not completed safeguarding training. However we were unable to access training records from the private company, as they were not being inspected.

Mandatory training

- All staff took part in mandatory and statutory training to ensure they were trained in safety systems, process and practices such as basic life support, conflict resolution, fire safety, infection control and health and safety.
- Many of the mandatory training modules were accessed thought the trust's online training system called ELMS. Staff reported positively about this system as they could track their own training and received reminders when it was due for renewal. Their manager was also received reminders so they could ensure all their team had completed their training. Many of the training modules were through online teaching sessions however some modules such as basic life support were still completed in a practical face-to-face session.
- All staff from the SPCT told us they had completed their mandatory training or were due to complete it in the new few weeks. Records showed the SPCT had reached 100% compliance in 12 out of 18 subjects. Those modules that had not been completed were due to only one member of the team still being required to complete a module. Most of the staff reported having time to complete their training and managers told us they supported staff in finding time to complete it if their workload was preventing them from doing so.
- Porters told us they had received mandatory and role specific training when they were employed directly by the trust however since being employed by the private company that took over the porter services they no longer received mandatory training.

Assessing and responding to patient risk

- We found that patients supported by the SPCT were regularly assessed by the SPCNs and any changes in the patient were identified quickly. Care plans were updated and discussed with the nursing team caring for the patient day-to-day.
- We found a mixed response in how well the nurses on the wards recognised a patient was approaching the last 12 months or less of life. For example if we asked staff if there was anyone at the end of life, they told us there was not. However if we asked if there was anyone with a DNACPR or anyone they would not expect to live longer than twelve months they would identify more people, therefore they were not connected with thinking that end of life was the last 12 months of less of life. Some of the SPCNs expressed concerns whether some generalist nurses and some doctors had the experience to recognise a patient who was deteriorating and how to care appropriately for a patient reaching the end of their

life. This varied recognition could mean some patients would not receive the right support and in the way they would like it; and there could be a lost opportunity to discuss advanced care plans in a timely manner.

- Most of the staff we spoke withon the wards were aware they could access advice and request specialist support from the SPCT and knew who their link SPCN for their ward was. However the SPCNs were concerned that they would not request the support if they did not have the necessary skills to recognise that a patient had deteriorated in the first place.
- At the end of life there are inevitable changes to the body such as their weight and skin integrity. Staff used tools to assess risks to patients, such as a pressure damage risk assessment tool to identify and prevent pressure ulcers. We saw the assessments were completed fully on the trust's electronic patient record system. Appropriate pressure relief mattresses and advice on how to reduce the risk of pressure trauma and maintain healthy skin was provided to patients assessed at risk.
- The trust used the national early warning score system (NEWS) for monitoring acutely ill patients. This alerted staffto a deterioration in the patient's condition.
- Where the progression of a patient's illness was clear, the amount of intervention was reduced to a minimum, with the focus based on ensuring the patient was as comfortable as possible at all times.

Nurse Staffing

- Commissioning guidance suggests the minimum requirement for specialist palliative care nurses (SPCN) is one SPCN per 250 beds. Northwick Park Hospital has 463 beds and Central Middlesex Hospital which the team support has 214 beds. The SPCT had a staff establishment of one whole time equivalent (WTE) band 8a and 4.8WTE band seven clinical nurse specialists (SPCN). There was one WTE vacancy which had recently been recruited to and awaiting a start date.
- The SPCNs worked closely together and talked on a daily ad hoc basis about their patients. The SPCNs had four to six weekly informal one to one support from a senior nurse where they could discuss their caseload, any patients of concern and share any learning. All the staff spoke positively of the support they gave one another and said the patients were the whole team's responsibility so anyone one of them could pick up their colleagues caseload if there were any unplanned absences.
- The SPCT were supported by a lead nurse for cancer and palliative care, who was in turn supported by the divisional head of nursing.
- A 0.8WTE administrator supported the SPCT.
- The trust had identified EOLC link nurses on the hospital wards who were going to be given extra training in EOLC and identifying dying.

Medical Staffing

- Commissioning guidance suggests the minimum requirement for consultants in palliative medicine is one WTE per 250 beds. The SPCT had one 0.8WTE consultant shared between three consultants (two 0.8WTE and one 0.2WTE) and a 0.7WTE speciality trust grade doctor.
- Consultant support was available outside of hours through the hospice.

Are end of life care services effective?

Requires improvement 

Patients were at risk of not receiving effective end of life care withinNorthwick Park Hospital. The SPCT was made up of a highly skilled and knowledgeable staff group which, supported patients with palliative care, and end of life patients with complex health needs. The SPCNs provided effective support and advice to staff supporting patients with palliative or end of life needs. However there were concerns some ward nurses, doctors and consultants lacked the expertise or experience to recognise when a patient was in the last 12 months or less of their life or was rapidly deteriorating due to being at end of life, especially if the patientwas frail and elderly. This meant some patients continued to receive treatment when it was no longer beneficial to themand could cause them discomfort and distress at a time they needed to be made comfortable.

Specialist staff also expressed concerns that generalist staff did not have the skills to have difficult conversations with patients or families. We found during our inspection that ward staff did not always identify with patients who were at

the end of life although they were aware of patients who had a 'do not attempt cardio pulmonary resuscitation' (DNACPR) order in place, and therefore likely to be at the end of their life. This meant patients may not have the opportunity to discuss their wishes, put in place any advanced directive and receive care which was appropriate to their circumstances.

The trust had identified the need for all staff to complete a training module in end of life care and recognising dying. The trust had recently approved funding to develop an e-learning package for all staff to complete. However, the SPCT expressed a concern about engaging consultants and doctors in this and nursing staff were concerned time would not be made available for them to complete the training unless it became mandatory for everyone.

The trust had responded to the phasing out of the 'Liverpool Care Pathway' with a holistic care plan called the 'Last Days of Life Care Agreement' (LDLCA). This document was not compulsory to use although all staff were expected to consider the five priorities of care which took into account a patient's wishes, and emotional, psychological and spiritual needs. We saw thatthe LDLCA was fully completed for those patients who had one; the plan of care and reasons behind the decisions was clearly documented. However we found it hard to navigate and gain a clear understanding of the patient's wishes and agreed care plan where this document was not used as we had to read the patient's notes to pick out the decisions.

The trust took part in a minimal number of national and local audits. Theservice level leadsexpressed the need to collect more complexinformation to understand patient outcomes and improve on services.

We found that staff did not always complete 'do not attempt cardio pulmonary resuscitation orders' (DNACPR)in line with best practice and national guidance. The trust audited the DNACPRs and had an action plan in place to improve their completion.

Evidence-based care and treatment

- The trust's response to the independent review of the use of the Liverpool Care Pathway (LCP) for the dying patient and the subsequent announcement of the phasing out of the LCP was to create a document call 'Last Days of Life Care Agreement' (LDLCA). This was available on the trust's intranet with supporting documents such as information for relatives and carers about when someone is dying. We observed ward staff being shown by a SPCN where to find the documents and how to use them. Staff who used the LDLCA spoke positively of it as it gave them a clear plan of care agreed by all those involved.
- We saw that whenstaff searched for EOLC on the trust's intranet it directed them to a page about Chaplaincy and bereavement services and did not given any advice or links to EOLC. We pointed this out to the senior SPCT staff and they said they would take this up with the team as it was a lost opportunity to promote the difference between palliative and EOLC.
- End of life care was managed in accordance with national guidelines. The LDLCA document guided clinicians through a series of prompts to discuss with the patient and those close to them. This assessed the patient's personal and clinical needs, their preferences and wishes, and the amount of intervention they wanted. It gave clinicians support in explaining why some clinical interventions may not be appropriate and what happens when someone is dying. The care plan was holistic, shared with colleagues and delivered in line with best practice. This document was not compulsory to use. However clinicians were expected to consider documenting a holistic care plan and to recordthe outcome of the discussion in the patient's records.
- The EOLC documents used achieved the 'Priorities of Care for the Dying Person' as set out by the Leadership Alliance 2014 for the Care of Dying People. Records reviewed showed open communication with the patient and family, recognition of dying, symptom control, and assessment of nutrition and hydration needs; and guided clinicians to discuss the patient's wishes and those involved in the patient's care, and toconsider the emotional, psychological and spiritual support they may need.
- Records reviewed met with the draft National Institute for Health and Care Excellence (NICE) guidelines 2015 for EOLC for review, and the Leadership Alliance 2014 five priorities for continual review of symptoms and discussion/communication with the patient and people important to them. We observed a written evaluation of care, and discussions and reviews carried out were completed in the patient's records three times a day by a doctor as well as the symptom checklist being completed by the nurse six times a day.

End of life care

Pain relief

- We found thatanticipatory prescribing followed the new draft NICE guidelines for symptom control. Some pain control was managed with PRN ('pro re nata' / as required) paracetemol. Patients told us they had received pain relief and their pain was dealt with effectively.
- The SPCT's consultants, doctors and nurses were experts in their field and able to provide guidance on the most effective and appropriate treatments and care at end of life, which included pain relief, nausea and vomiting.
- Where appropriate, patients had syringe drivers which delivered measured doses of drugs over 24 hours. All qualified nursing staff were trained in using syringe drivers and symptom management.
- Some of the SPCNs were able to prescribe medications appropriate to supporting patients at the end of life. This meant patients could access some medications without needing to wait for their doctors to prescribe it.

Nutrition and hydration

- Nutrition and hydration needs were identified in the patient's care plan as part of the 'LDLCA. Prompts for staff to follow when explaining nutrition and hydration were included in the agreement and there was space to write what was discussed and the patient and families response to the discussion.
- Staff assessed each patient and support and guidance was provided on an individual basis. Input at EOL was around supporting the family when a patient stopped eating and drinking due to entering the dying phase. The SPCT was also involved in the MDT meeting and supported patients and families in the decision making process of when to reduce enteral feeding.
- Patient's oral fluid and food intake was encouraged as long as the patient was able to swallow and wanted to eat and drink. Hydration and nutrition needs were monitored and reviewed with the patient and people important to them and nurses acted on any concerns.
- Subcutaneous fluids (artificial hydration) were considered if it was seen to be in the patient's best interests. It is unclear whether giving parenteral fluids to people who are dying causes, rather than alleviates, symptoms. Therefore every case was considered on an individual basis and the reason to administer or not was explained to the patient and family.

Patient outcomes

- The trust participated in the National Care of the Dying Audit – Hospitals (NCDAH). The audit was made up of an organisational assessment and a clinical audit. Northwick ParkHospitalhad achieved four out of seven key performance indicators (KPI) in the organisational audit and seven out of ten KPIs for the clinical audit. The three KPIs they did not achieve were:
- Care of the dying training was not mandatory for all clinical staff who worked with dying patients this was achieved by 40% of trusts.
- No public and patient representation for planning care of the dying within the trust.This was achieved by 28% of trusts.
- Face-to-face access to specialist support was not available seven days per week. 21% of trusts achieved this.
- The SPCT had analysed the main findings of the audit and had proposed a number of recommendations to improve the service, such as providing EOLC training at induction as part of mandatory training. The action plan clearly outlined the recommendation, progress and completion dates.
- The hospital had submitted data for the most recent NCDAH and the results were due in May 2016. This would show whether improvements had been made since the last audit.
- The hospital provided data to Public Health England's 'Minimum Data Sets (MDS) for Palliative Care'. The aim of the MDS is to provide good quality, comprehensive data about hospice and specialist palliative care services on a continuing basis. The data is useful for service management, monitoring and audit, development of strategy and service planning, commissioning of services and development of national policy. The trust had very recently received the results for 2014/15, and they were currently reviewing how they performed against other organisations of a similar size to them at a national and local level.
- Thetrust took part in the 'London Cancer Alliance Palliative Care Audit'. This showed how the hospitals and hospice performed against other providers across London. The comparison of numbers of individuals seen

by Northwick Park (and Central Middlesex) Hospital had seen an increase from 695 in 2011-2012, to 841 in 2013-2014. This was a 21% increase in comparison to the average across London of 6.1%.

- Since our last inspection of Northwick Park Hospital in June 2014, the results of a service development programme to reduce the number of admissions to hospital for patients with long-term conditions or who are frail and elderly in the last years of their life had been completed by the two Darzi Fellows. The May 2014 report had demonstrated that advanced care planning (ACP) with the patient in hospital had reduced readmission to hospital. Seventy patients were referred for an ACP and 90% of them had a completed ACP prior to discharge. Of that number,2% had been readmitted within 30 days. Thirty patients with a ACP died by the 30 day follow up and 100% of them died in their preferred place. At that time none of the patients referred for ACP had died in hospital. As a result an improvement project for advanced care planning was being implemented and a clinical post to support the work had been advertised.
- Northwick Park Hospital consultants provided a 'virtual ward' in the community. This scheme was to support patients who have long term chronic conditions, from which they were not going to recover,to stay intheir own homes. Specialist consultants, such as respiratory and heart failure, and the CPCT visited Harrow patients in their own home to support them in managing their condition(s) and discuss advanced care planning which prevented them from unnecessary admissions to hospital. We were told of one patient who had five admissions over a 12 month period, and since they had been on the scheme they had not been admitted to hospital.
- The hospital did not take part in the bereavement audit (this is an optional part of the NCDAH) as they did not collect next of kin data. This information was contained in the LDLCA. However not every patient that died under the trust's care was supported using this plan and therefore the information collected would not be reflective of all deaths in the trust. The trust had also withdrawn the bereavement coordinator post and this had brought this planned piece of work to a halt.

Competent staff

- The SPCTs were made up of competent and highly trained individuals. A majority of staff reported having the opportunity to develop and attend further education courses in line with their role. Although at times workload meant they were unable to attend as many course or conferences as they would like to.
- The SPCT business meeting minutes dated 29 September 2015 identified that the mock CQC inspection they ran showed that staff had a poor understanding of the LDLCA and EOLC. A promotion stand was instigated atNorthwick Park Hospitalin October 2015to promote EOLC and LDLCA to staff.
- There were some concerns raised by specialist staff that some doctors and consultants did not have the skills or expertise to recognise when a patient was not going to recover from their illness and in the last 12 months of life or less, and therefore did not consider discussing advanced care planning.
- Specialist staff also raised concerns that some generalist nurses and doctors did not have the skills to recognise a patient who was in the dying stages and as a result could be continuing with treatment that was no longer going to help the patient. We were given several examples of patients who were receiving treatment that was not appropriate as they were dying. We observed one SPCN removing the oxygen from a patient at the end of life as it was no longer improving their blood oxygen saturation. The nasal cannula was causing the patient discomfort, this was explained to the ward staff and a note was made. When the SPCN returned the following day the oxygen had been reinstated without any effect. The SPCT provided support and training to generalist staff. Each ward had an appointed SPCN, the ward staff were aware of the SPCN contact for their ward. We observed the SPCNs spent time with nurses and supported them in identifying the patients care and treatment needs and any changes. Some of the SPCNs visited the ward staff under their responsibility on a daily basis while others visited according to their workload. However they said they would usually visit at least once a week to see if staff had any support or training needs.
- A teaching package was being developed for newly qualified and overseas nurses. The main topics would be the five priorities of care, LDLCA and their responsibilities.
- The trust had successfully bid for funding from the Health Education North West London (HENWL) to pilot an EOLC training pilot on the care of the elderly wards at Northwick Park Hospital. The elderly care wards were

chosen based on the high frequency of deaths encountered such that end of life care was part of the daily role of the professionals. The training was for doctors and ward staff of all grades. It was also for EOLC champions identified as having a special interest in the care of patients at the end of life., whowith extra training had the skills to support colleagues in recognising dying and supporting patients and those close to them. The objective of the pilot was to:

1. Improve multidisciplinary team (MDT) knowledge, skills, attitudes and confidence in managing patients at the end of life.
2. Identify, train and develop recognised multi professional champions for EOLC that act as a resource and a role model for best practice on each ward.
3. Develop a model of training that could be replicated to all other wards, different members of the MDT anddifferent settings such as nursing homes and community.

- The pilot's evaluation indicated that staff who attended the course benefitted from an increase in knowledge and confidence although staff also expressed a concern that despite their increased confidence and knowledge, poor staffing and high workload would prevent them from delivering quality EoLC.
- The resulting recommendation was for mandatory training with e-learning for all those involved in EOLC; with more focussed face-to-face sessions for those staff who frequently encountered patients at the end of life. At the time of our inspection, the trust were developing an e-learning package for all staff to complete as part of their mandatory training.

- Generalist and specialist nurses and doctors who regularly supported patients at the EOL could take a secondment opportunity at Meadow House Hospice in order to gain further confidence and expertise in supporting patients who had life limiting illnesses or were at the end of their life.
- Sage and Thyme® communication training was available to all staff in the trust, including administrative staff and porters. This training was designed to train all grades of staff in how to listen and respond to patients/clients or carers who are distressed or concerned. Staff who had undertaken this training spoke positively about it as they were more confident in having a conversation with someone who was distressed or concerned.
- The palliative medicine consultants and SPCNs took advanced communications skills training so that they could support patients and families through difficult conversations and breaking bad news. Eight out of ten of the team had completed their training.
- Porters were employed by a private company and reported to not have received any training specifically relating to end of life, such as moving the deceased from the ward to mortuary and supporting people close to the deceased at viewings. The porters we spoke with said they tried to consider things from the bereaved person's point of view. At our last inspection porters were receiving bereavement training from the bereavement officer. However this post had been made redundant and the training was no longer supported.

Multidisciplinary working

- A multi-professional team made up of consultants in palliative medicine, SPCNs, an administrator and haplain met on a weekly basis. The team discussed new referrals, complex cases and identified extra support they or the patient required, such as clinical expertise or social or psychological support. We observed the team assess and plan on-going care, which included moves between teams or services such as discharge to a community or home setting.
- Each team member presented their cases clearly and showed a great understanding of each of their patients and those close to them from a clinical, emotional, spiritual and psychological need. The team discussed care plans, which were individualised and based on the patient's wishes and needs. We witnessed staff of all levels were clear and open challenge between each other.
- There were clear pathways between the hospital and community settings to facilitate patients being discharged (if safe to do so) to home, hospice or care/ nursing home.

Seven-day services

- The SPCT provided face-to-face support from 8am to 5pm Monday to Friday. The trust's action plan to address the deficiencies in the 2014 NCDAH was to

increase face-to-face contact from six to seven days per week. However since our last inspection of the hospital the service had been reduced from six days to five days per week due to a shortage of specialist nurses.
- The two local hospices provided a 24-hour helpline for clinicians. They triaged the calls and directed the caller to the most appropriate support, such as the on-call SPCN or consultant.

Access to information

- During September and October 2015, the trust had migrated patients' electronic records from one electronic patient record system to another, with an aim for more accessibility and improved information sharing opportunities across the trust.
- Patients who were identified as at end of life and had advanced care plan and/or a do not attempt cardio pulmonary resuscitation (DNACPR) were entered onto an electronic record called 'Coordinate My Care' (CmC). The patient's illness, wishes, such as preferred place of death,and personalised urgent care plan could be accessed by anyone involved in the their care, such as their GP, community nurses, hospital team, out-of-hours doctors, specialist nurses, and ambulance service. This allowed them to know what care they should deliver to the patient. The trust audited the number of patients entered onto CmC and 100% of those eligible to be on CmC had been included for the period between April and October 2015.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff undertook Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training as part of their mandatory equality diversity and human rights training. We gave hypothetical situations to the SPCNs and consultants. They were able to describe accurately the process they would follow should someone be found to not have consent to agree to treatment or be able to make decisions in relation to their care. This included consulting with people who were close to them to gauge what the patient would have wanted in order to make best interest decisions.
- MCA and DoLS guidance was available on the trust's intranet and associated documents such as the consent policy, dementia policy and safeguarding adults at risk policy.
- The policy for consent to examination or treatment was available to staff on the trust's intranet. This was under reviewed at the time of our inspection. We found it was referenced to the Mental Capacity Act (2005). Amental capacity assessment checklist and a consent training competency proforma were included in the policy.
- Staff could access support and advice from the hospital social workers in relation to the MCA and DoLS.
- We reviewed five do not attempt cardio pulmonary resuscitation (DNACPR) forms and found their level ofcompletion was variable. For example, one form had not been completed or signed by a clinician with sufficient seniority; and another patient had two DNACPR orders which created a confusing picture.The first one had been completed correctly and the second most recent one was incomplete, and there had been no discussions with anyone important to the patient.
- DNACPR forms completed in acute settings were not transferrable with the patient to their home, care/ nursing home or hospice, therefore the patient's GP was responsible for completing a DNACPR directive as soon as possible after the patient reached their home. This ensured all interested parties fully understood the process.
- The trust-wide DNACPR audit report dated November 2015 looked at 155 DNACPR orders across the three hospital sites (Northwick Park [93 patients], Ealing [33 patients] and Central Middlesex [29 patients]). The audit identified areas of good and poor practice.
  - The audit found that in 26 cases there was no summary of communication documents with either the patient or those close to them; 46 patients had capacity to make and communicate decisions about CPR and 101 lacked capacity; there was no documentation for seven patients.
  - 150 DNACPR forms had the date of the decision recorded and 114 forms had the time of the DNACPR recorded.
  - 140 DNACPR forms had documented the grade of the doctor making the DNACPR decision, 105 of these decisions were recorded by a registrar or above grade doctor, and four forms had been completed by a Senior House Office/FY1 doctor.
  - Good practice included name, hospital/NHS number, address, DNACPR decision being recorded and the number of patients who had a capacity assessment.

End of life care

The audit report made recommendations for improvement such as documenting the reasons why CPR would be inappropriate, summary of communication with patient and those close to them and a summary of main clinical problems identified and documented. The immediate actions taken included consultants completing the review dates and documenting them, assessing patient's capacity and signing the orders; sharing the findings of the audit with ward staff; and a request that DNACPR status is reviewed by the medical multidisciplinary team. Further analysis was planned to identify any trends and themes and the results were going to be RAG rated; this is a traffic light system (red, amber, green) to identify the level of risk.

Are end of life care services caring?

Good

The support and care given to patients identified as at the end of their life and after death was good. We spoke with four patients and five relatives in different wards around the hospital. Patients told us although the staff on the wards were "very busy, they were very kind."

Patient's privacy and dignity was maintained and we observed staff asking permission to enter a patient's room or bed space if the curtains were closed. Patients were addressed by their preferred named and a ward nurse was identified each day as their main carer. Staff introduced themselves, explained what they were doing and why, even with patients who were not completely aware of their surroundings or very conscious.

We observed positive interactions between staff and patients and most staff were able to give a clear account of the patients' circumstances and family/social background. There were a number of resources available for emotional support for patients and those close to them which included clinical staff, a multi-faith chaplaincy service and Macmillan cancer care services.

Patients and those close to them told us they were involved in decisions about their care and took into account their wishes. They had time to ask questions and were provided with explanations to their queries. However we noted in some care records the patients or relatives views were not detailed fully although discussions had taken place. Wealso observed that general nursing tasks, such as moving patients regularly to ensure the patient's comfort and prevent pressure ulcers, could be seen as being "too caring" as the need for turning the patient had not been explained to their visitors and they saw this asan unwanted and inappropriate interference at the end of life.

Compassionate care

- We visited patients on the wards and observed that all the staff treated patients and their families with respect and worked hard at maintaining people's dignity. Staff sought permission to enter the patients' bed space prior to entry. We heard staff introduce themselves to the patient if they had not seen them before or to remind the patient of who they were.
- We observed staff provide care and support. We noted how they took great care to explain what they were going to do and how they were going to do it, and ensure that the patient, and family if appropriate, were happy for the care to be undertaken.
- Patients and families told us they were very happy with the support they received from the nurses. One person told us "the nurse that has been looking after me for the last two days has been exceptionally nice and kind, nothing is too much trouble."
- The 'Last Days of Life Care Agreement' (LDLCA) reflected patients' personalised needs. This meant that the whole team supporting the patient and their carers could provide support in a consistent way, therefore ensuring the patient was treated in a compassionate way and without performing unnecessary interventions at a time the person was actively dying.
- Porters and mortuary staffsaid thatthe bodies of deceased patients were handled in a compassionate way and there had not been any concerns about the condition of the bodies when they arrived in the mortuary area.
- Two porters always collected bodies from the ward area. We found their approach in performing this role was considered and caring as they were concerned about the deceased and they thought about the family's feelings. They told us that the transfer from the wards to the mortuary was rarely a smooth or seamless journey. They found that bed spaces were cramped and made it difficult to transfer the body from the bed to the concealment trolley; it required them to move tables and chairs out of the space before the transfer which caused a disturbance to others and identified what was happening; and they regularly had to wait a long time to

use the service lift to transfer the body due to domestic staff blocking the doors open to prevent anyone else from using it. The portersreported that the process could be undignified for the deceased.
- A deceased person's possessions were kept by the bereavement office in an individual bag and returned to family members when they collected the death certificate. This meant they did not need to make multiple trips to the hospital unnecessarily.

Understanding and involvement of patients and those close to them

- Patients were given a named nurse on the wards. This allowed patients and those close to them to identify who was responsible for their care. The SPCNswere allocated patients as theywere referred to the SPCT. All the team members were aware of the patient should they need to support them in their colleagues absence. Multiple staff contact was kept to a minimum for consistency and to gain greater understanding of the patient and their personal circumstances.
- Patients who were identified as approaching the end of their life were given the opportunity to create an advanced cared plan. This gave patients the time to discuss their preferred priorities for care and make decisions about where they would like to be cared for and how. This care was planned and delivered in a way that involved the patient and those close to them. Care plans took into account the patient's and their family's wishes, social circumstances and environmental practicalities.
- We found all the SPCNs and most of the ward nurses had a good understanding of their patients and what was important to them. They spoke about their patients in a personable and caring way. Those nurses that did not know their patients well were generally newly qualified and were relying on their mentor's knowledge.
- We spoke with one family regarding the LDLCA. It had been agreed by one family member that it should be used as a way of supporting their dying relative. However the following morning due to the patient's relatives not being in agreement they asked for the LDLCA to be withdrawn as they were worried their relative would think they were hastening their death. The team understood the family were feeling guilty about accepting their relative was dying and at their request "treated them as a normal patient" by reinstating some regular observations such as blood glucose monitoring, food intake and urine output. The patient was informed of this and the change to their planned care via an interpreter as English was not their first language.
- Records showed some discussions between clinicians and patients and those close to them. In some cases the views of the family were detailed, while others only stated that the family member understood theplan. One familymember said, "everyone is very good. If anything they are moving my relative and caring for them too much. My relatives just wants to be left alone" We ascertained that they family were unaware of the importance of moving patients who cannot adjust their position by themselves as staff had not explained this. Once we had clarified the reason they understood the importance of the staff moving them.
- One patient told us that there had been no discussions about their future. The patient did not appear to know how unwell they were and expressed a wish to us that they wanted to go to a nursing home. We observed a request in their care records from the psychiatrist informing staff of the need to keep him informed about their deteriorating health. However there were no notes from staff to indicate that this was happening. We observed the notes did not give a coherent picture about, and plan for, this patient. We broughtthis to the ward manager's attention, who reassured us they would follow it up.

Emotional support

- The SPCNs, ward staff and chaplain gave emotional support to patients and their relatives. Staff told us they would give them as much time as they needed to talk about their thoughts and feelings. They told us of other agencies which could offer support to the patient and those close to them, such as counselling services and spiritual/faith/religious leaders.
- The hospital's multi-faith chaplaincy service was available to support patients and we saw evidence of staff offering this service. Patients and families were able to arrange for their own spiritual leader to visit the hospital.
- The bereavement officer supported relatives and friends after a patient's death by explaining all the legal processes and what to expect when someone has died. An information pack which included contact details for support and counselling groups was provided.

End of life care

- Emotional support extended to the clinical team through peer support and one to one clinical supervision. Staff told us they could take some time out if they found it hard to cope at any point. However this was said to be rare as the day to day support they gave each other was usually enough.
- The chaplain held a number of services people could attend in order to remember their relative who had died at the hospital.

Are end of life care services responsive?

Good

The trust's draft end of life care strategy took into account the importance to plan and deliver services that provided patients with flexibility, choice and continuity of care whether they were in a hospital or community setting.

We found the hospital SPCT liaised with community services to ensure they understood how each other worked and identify any differences in the approach and systems they used. The aim was to provide patients with seamless and equitable EOLC wherever they chose to be supported and to decrease the number of unplanned and inappropriate admissions to hospital when someone was reaching the end of their life.

We found that the LDLCA was individualised and holistic to reflect the patient's needs and wishes, and took into account the views of the people who were important to them. However this was a new document and not all health professionals had started to use it. This meant there could be potential gaps in the discussions held by clinicians who may only take into account the patient's clinical needs and not enter into other issues that could be important in the patient's care.

Patients with cancer and non-cancer diagnosis were referred to and supported by the SPCT. They regularly received over 100 referrals each month and support from the SPCNs was provided in a timely manner.

Patients were supported in being transferred to their preferred place of death through a 24-hour rapid discharge process. The hospital did not collect figures on how many patients had died in their preferred place. However the team were aware of the reasons that it was not achieved for some patients, such as rapid deterioration or community services not being readily available.

There was no specificstrategy in place to monitor preferred place of death for all patients.

The chaplaincy, mortuary and the bereavement office took into account people's religious customs and beliefs and were flexible around people's needs. For example, some cultures required the release of the deceased's body within 24 hours of death. There was suitable service provision at night and at weekends to accommodate this. There was a multi-faith chaplaincy service supported by full-time and part-time spiritual leaders from different denominations.

There were very few complaints about EOL services. The SPCT told us they monitored any EOL concerns through the complaints office as complaints were investigated against the ward the patient was admitted to. This allowed the team to identify any trends and support staff if there were any learning or development requirements.

Planning and delivering services which meet people's needs

- London North West Healthcare NHS Trust was a newly merged service comprising three acute hospitals, three community in-patient units (Meadow House hospice, Willesden Hospital and the Denham Unit) and community services for three London boroughs (Ealing, Brent and Harrow). The draft EOLC strategy stated 'across this area around 100 people die each week, many of which will have a predicted death, even if only recognised in the last days or hours. Whether they spend their final days in their own home, care home or as an in-patient, LNWHT staff have the opportunity to optimise the dying experience for both those at the end of their lives and those left behind'.
- The aim of the strategy was to ensure that all people reaching the end of their life received the most appropriate care and support for their own circumstances and avoid unnecessary hospital admissions for those that wished to be cared for outside of a hospital environment. This included providing generalist high quality EOLC which could be delivered by non-specialist health and care staff as part of their core work provided they were given education, training and support to do so.

- The SPCT leads gave us examples of how they engaged with the CCGs, GPs and other social and healthcare providers in addressing the needs of the local population to provide a joined up EOLC service. The EOLC group included clinical, non-clinical and user group representatives from the acute and community settings.
- The SPCT met on a monthly basis with community providers to liaise about patients who were using acute and community services so thatthey could support the patient appropriately. Staff spoke positively about these meetings as they were gaining a clear understanding of each other's services and practices which mean patients had a better plan of care.
- Northwick Park Hospital consultants provided a 'virtual ward' in the community. This scheme was to support patients who have long term chronic conditions, from which they were not going to recover from, in staying their own homes. Specialist consultants, such as respiratory and heart failure, and the CPCT visited Harrow patients in their own home to support them in managing their condition(s) and discuss advanced care planning which prevented them from unnecessary admissions to hospital.
- The hospital did not have dedicated end of life beds. Patients identified as being in the last days or hours of life were mostly cared for on general medical and surgical wards. Staff told us where possible patients were moved to a side room to offer more privacy when they were nearing the end of their life; and if this was not possible due to the number of patient on the ward and their nursing needs, curtains were drawn around their bed.
- Specialist palliative care beds could be arranged at St Luke's or Michael Sobell hospices through the SPCT dependent on the needs of the patient. SPCNs told us that ward staff occasionally raised patients' hopes by suggesting a hospice bed could be arranged.This was not always possible as beds were not always available. It was then left to the SPCT to manage the patient's expectations which on occasions was reported to cause disappointment.
- The 'Last Days of Life Care Agreement' commenced when the patient was recognised as likely to be in the last days or hours of life. Consideration to whether the patient had an advanced care plan, or an advanced decision to refuse treatment, a lasting power of attorney (LPA) for health or wish for organ donation was included. The agreement recorded the discussions held with all the individuals involved in making care decisions at this time and included people important to the patient.

Access to the right care at the right time

- Any healthcare professional in the trust could refer patients to the SPCT. From 1st January to 1 October 2015 there were 1,119 inpatient deaths at Northwick Park Hospital. During this period 955 patients were referred to the SPCT; 61% had a cancer diagnosis and 39% had a non-cancer diagnosis. This indicated that patients with a non-cancer diagnosis also received specialist support from the palliative care team if required.
- The SPCT engaged with palliative and EOL patients as early in their treatment as they could. They saw urgent referrals within 24 hours and non-urgent referrals in 72 hours. The SPCT saw 93% of urgent patients within 24 hours and 85% of all patients within 24 hours (including the weekends). They saw 100% of non-urgent cases within a72 hour target. Patients who were not seen were due to the patient dying prior to seeing them or patients being discharged from the hospital to home or a community provider.
- Each of the SPCN was responsible for designated wards,which meant staff had access to regular specialist support. The ward staff knew who their lead SPCN was and spoke positively about the support they received. We observed ward staff asking for assistance or guidance, and the SPCN supporting staff when there was a change in the patient's condition.
- OOHs consultant cover was accessed through Michael Sobell Hospice and Meadow House Hospice and the contact details were included in the LDLCA. This gave patients, carers, GPs and community nurses access to immediate professional specialist advice.
- Early identification of patients who wanted to die at home, care/nursing home or hospice was part of the wards' EOLC link nurses' responsibility. Staff made every effort to transfer a patient to their preferred place of death within 24 hours if all the relevant assessments and community resources were readily accessible. Sometimes patients were not discharged and transferred to their preferred place as it was not in their best interest, for example , ifthe home environment was not suitable to support them in, or the patient had

rapidly deteriorated and it was unsafe to move them. Some patients' discharges failed due to anticipatory medication not being available for them to take away and transport issues. Staff raised these as incidents when they happened. Preferred place of death was not being monitored at the time of our inspection. The SPCT manager acknowledged the need to in put more data on to the electronic systems as they were starting to see the need for more statistics in order to ascertain how well the service was performing against key benchmarks.

Meeting people's individual needs

- We did not find any records indicating that advanced care planning (ACP) had been put in place for any of the patients' notes we looked at, or patient and relatives we spoke with. However the LDCDA reminded staff to ask if there was an ACP in place, which could have been discussed with the patient's GP.
- We found that care planning in the last days and hours of life was individualised and holistic to reflect the patient's needs. The LDLCA looked at the whole picture and took into account the views of the patients and carers and their spiritual, emotional, psychological and social needs. The patient's preferred place of death was documented and this was shared with the other professionals involved in their care. However this was a new document and not all health professionals had started to use it for patients identified at end of life. This meant there could be gaps in the discussions held by clinicians who may only take into account the patients clinical needs and not enter into other issues that could be important to the patient or those important to them.
- A number of the SPCNs had other specialist backgrounds due to their previous nursing roles, such as respiratory or cardiology. This meant they could support patients with cancer diagnosis and other complex illnesses which were life limiting and were aware of the complications each illness could have and how they interacted with one another and what contra-indications there could be when treating more than one illness, therefore tailoring their care to the patient's individual needs.
- We reviewed the trust's revised draft strategy for people living with dementia. The document identifies that 'Alzheimer's disease is one of the top causes of premature death in the UK, accounting for 2.6% of years of life lost in the 2010 'Global Burden of Disease Study'. People with dementia stay in hospital for longer, are more likely to be re-admitted and more likely to die than patients admitted for the same condition without dementia (Care Quality Commission (CQC) 2013).' The strategy focussed on how to improve the inpatient experience for those living with dementia through changing attitudes, the environment, raising awareness and having clear pathways for treatment and care. However it did not specify how to support patients in advanced care planning and finding ways to decrease inappropriate hospital admissions at EOL.
- Normal visiting hours were waived for relatives of patients who were at the end of their life. One family told us, "we are a large family and we are really happy that we can visit when we want to, it really helps with for those of us who work."
- Patients' close family members were able to stay with their relative overnight and the facilities and arrangements were different for each ward at the hospital. There was no dedicated accommodation for patients' relatives. However there were facilities to buy refreshments and staff would show them the nearest toilet and washroom facilities.
- Most of the adult wards did not have adequate space to hold private conversations or for relatives to have some personal time away from the ward. Staff told us space at the hospital was at a premium and sensitive conversations were sometimes held in the corridors, which was not appropriate.
- Staff were aware that different cultures had a different approach to death and dying. For examples some cultures were very open about discussing it while others did not discuss death and had a strong belief in medical cures and talking about death means that you are giving up on the person. Therefore the team approached difficult conversations about death and dying at a pace that the patient and family could understand.
- Patients and relatives could access a chapel and a multi-faith prayer room if they wished. The chapel was not open at night and the chaplaincy thought this was a gap in the service provided. There was a full time Church of England and a Roman Catholic chaplain available. Leaders from other faiths (Hindu, Jewish and Muslim) were available on a part-time and on-call basis.
- The mortuary was undergoing a refurbishment, however disruption in the mortuary viewing area was kept to a minimum. The surroundings were neutral in decoration and did not identify with any religious denomination.

Religious insignia for different faiths was available on request. However, there was nothing to indicate that visitors to the mortuary could ask for this. Mortuary staff told us there were no facilities for religious washings.
- The hospital did not have a bariatric trolley to transfer bodies that were too large for the usual mortuary trolley. However staff had identified a way of transferring these deceased patients which maintained their dignity.
- The hospital had a bereavement office and private room, which was appropriately furnished. Staff provided relatives with information, the death certificate and a booklet on what happens after death. This information sign posted relatives to organisation they might find helpful. Staff did not provide counselling services.
- The bereavement and mortuary services took into account people's religious customs and beliefs and were flexible around people's needs.
- The trust had access to translation services through language line or face-to-face interpreters. There were a number of staff who spoke other languages and we were given an example of a doctor discussing a patient's symptoms and prognosis using Arabic.

Learning from complaints and concerns

- End of life services received very few formal complaints. We were given a clear explanation of how complaints were handled and the role of the service managers in responding to them. All staff told us they preferred to deal with issues or complaints immediately and offered a face-to-face meeting with the complainant. If they found the issue could not be dealt with in their way they supported people in making a formal complaint to the trust.
- Staff told us they liaised regularly with the complaints department so they were aware of any EOLC issues which maybe happening on the ward and did not directly involve the SPCT. This meant they could identify any trends and support individual staff or wards in learning and development.

Are end of life care services well-led?

Good

The trust had a clear statement of vision and values, driven by safety and quality. All staff we spoke with were committed to providing safe and good quality care and we found that most staff we spoke with understood the trust's vision however they were not always able to explain how it was going to be achieved.

All the staff we spoke with were positive about the leadership of palliative and end of life services and told us the management were visible and approachable. The leadership, governance and culture within the SPCT provided good quality person-centred EOLC. The senior staff prioritised safe, high quality compassionate care through clear lines of leadership and an emphasis on being open and transparent. There was a culture of collective responsibility between the team and many opportunities to discuss patients' needs and review cases.

The SPCT regularly engaged with staff on generalist and specialist wards by providing support, training and assessing the appropriateness of the care they were providing. Ward staff were aware of the specialist support available to them; some had sought support from the SPCT when they identified concerns in the way staff supported patients at the end of life.

A draft EOLC strategy had been completed and was in consultation stage at the time of our inspection. The strategy was developed by the trusts community and acute services through regular engagement with internal and external stakeholders, which included people who used the service, staff, commissioners and other organisations.

Staff reported an improved emphasis on EOLC at board level over the last year. However there was some doubt that it received the level of support required to effect enough change to provideseamless safe high quality care for all patients across the trust's community and acute services; and as it was still seen as the responsibility of the palliative and cancer services to drive it forward, the vision for EOLC to be everyone's responsibility would not be reflected.

Vision and strategy for this service

- We found there was a mixed response to understanding the trust's vision and strategy. Most staff we spoke with said the strategy and vision was to provide good quality safe care however they could not explain the strategy to achieve this.
- The trust had recently written the EOLC strategy which was currently in a draft format and out for consultation. The strategy identified that for the trust to deliver high

quality, equitable and compassionate EOLC core principles needed to be followed across the whole of the acute and community services. These core principles of EOLC included the recognition of the possibility that a patients might die, communicating clearly and honestly with the patients and family, understanding the priorities of care of the patient and family, and delivering co-ordinated care enabling the patient to die in the place of their choosing if possible.

- At a local level the SPCT were clear about the strategy and vision for palliative and end of life care service. However we found at ward level that this was not known. EOLC group meeting minutes showed how the EOLC strategy and vision was fed to the trust's board via the clinical cabinet and any feedback was discussed and recorded at the following EOLC group meeting. This group had representation from various directorates such as elderly care, A&E and AHP across the trust and therefore it was possible for this information to be disseminated to staff at all levels through each directorate across the trust.
- There was an aim to achieve the strategy through identification, advanced care planning, co-ordination of care, involving and supporting carers, education and training, and performance monitoring and research. This strategy committee included amongst others, a trust lead, trust board representation, palliative care, divisional representatives, nursing, allied healthcare professionals, chaplaincy, community representations, GPs and patients across Ealing and Northwick Park and Central Middlesex hospitals.

Governance, risk management and quality measurement

- We read in the end of life care group meeting minutes dated 11 August 2015 that the new board accountability and assurance structure had omitted to include the EOLC steering group. This could be seen as an indication as to how high EOLC is on the trust's agenda. However themeeting minutessuggested it to be an oversight. It wasrecommended they reported to the clinical cabinet chaired by the Medical Director or to the clinical quality and risk group chaired by the Chief Operating Officer. The following meeting minutes indicated this had been rectified and they reported to the clinical cabinet.
- We found that the governance framework and management systems were regularly reviewed and there was a drive to improve. A clinical governance meeting took place four times a year where incidents and risks were explored and any trends identified. For example, the acuity of patients had changed on one ward in the hospital and this had increased incidents around mouth care.Aknowledge gap in caring for patients at end their life was identified and training was put in place. There was a clinical lead and board representation for EOLC.
- There was a plan to sign up to the 'NHS Improving Quality Transform Improvement Programme'. However they required a designated service improvement lead before they could do this. We noted that meeting minutes had identified people who could possibly take on this role. The transform programme streams of work included: advanced care planning, electronic patient record for OOHs care, rapid discharge home to die, five priorities for care for the last days of life and care after death.
- An advanced care planning (ACP) nurse post was being advertised at the time of our inspection with an aim for them to target the care of the elderly wards to ensure ACP was considered and implemented where appropriate. This would ensure consistency in care, ensure the patients' wishes had been discussed and drive down unnecessary hospital admissions.
- The trust took part in a number of national audits, such as the NCDAH which they had just completed. There was a plan to audit the LDLCA in the next few months to see how accurately the document was being used and how well it supported patient care. After a recent review of 50 sets of deceased patients notes, the team had decided to review the notesof the first ten deaths each month (five from Northwick Park Hospital and five from Ealing Hospital) to feedback on the quality of recording and identify any gaps, trends or concerns.
- EOLC group meeting committee met every two months and included arange of staff from across the trust acute and community locations including consultants, SPCNs, the medical director, the divisional head of nursing, elderly care and the resuscitation officer. Recent minutes recommended identifying ward managers to attend the 'EOLC Group' meetings. The aim was to increase EOLC and the five priorities of care profile and encourage ward managers to take greater responsibility for monitoring care around their dying patients.
- The SPCTs held weekly MDT meetings and bi-monthly business and educations meetings. The team discussed

new and deteriorating patients and those that had chronic illness or were of concern. They considered the patients from a holistic point of view taking into account their social and psychological needs and assured that

- The SPCTs engaged with their acute peers and other SPCNs through meetings / informal discussions. The consultants worked within the community and at the acute hospitals. This allowed them to address issues or share learning with the teams and offered consistency in support for patients under their care.
- A clinical forum discussed and reflected on cases that were difficult or ethically challenging. Significant event analysis and death reviews allowed the team to discuss the outcomes for the patient and those close to them, identify any issues, learning and share good practice.

Leadership of service

- The lead for cancer and palliative care told us that when they first started at the hospital palliative and end of life care was “not on their [the trust] radar” and senior staff at the hospital were “not engaged” with it. However in the last year (since September 2014) they had found that the EOLC profile had increased and had a “larger voice” through the medical director. This had given the subject ”more authority”. They also expressed a concern that the structure for leadership was not right yet as having “clinicians at the heart of it doesn’t work” and it required a more shared approach at all levels to ensure equity for all patients at the end of their life. The consultant leads told us although there was trust board representation they did not feel that EOLC received the level of support it required to effect the change required to provide an integrated strategy that provided seamless safe high quality care for all patients across the trust’s community and acute services.
- There was a natural inclination for the trust to lean on the palliative care teams to lead on EOLC. The SPCTs were professional and were highly skilled in delivering palliative and EOLC. However they were not involved in caring for every patient who died in the hospital and therefore could not ensure everyone had the same recognition or quality of care as those with cancer or complex non-cancer diagnosis received. They told us they were passionate about all staff in the hospital providing a safe and good quality of care for end of life patients and therefore it was everyone’s responsibility and not just that of the SPCT to ensure this happened. Therefore they strongly encouraged other staff at all levels throughout the hospital to be involved in EOLC.This included bedside training sessions, being part of committees or meetings, nurse EOLC champions on the wards, and gaining board recognition.
- Staff told us they were supported by senior managers, in particular the divisional head of nursing and lead nurse for cancer and palliative care. They found them to be helpful, knowledgeable and approachable.
- Staff reported that leadership was visible, accessible and responsive. Local managers had appropriate knowledge and experience to lead services and they were well aware of issues and challenges their teams faced. We observed a flattened hierarchy which allowed for challenge and discussion. Staffperceived thattheir opinions were valued.
- There were clear lines of accountability within the palliative care management team. The clinical leads were enthusiastic and proactive in helping drive forward the end of life agenda within the trust. The clinical leads sat on the EOLC steering group which sat across the whole of the trust.

Culture within the service

- We observed a committed and caring group of staff within the SPCT. The staff were clearly committed to providing good end of life care for patients. They were proud of working in their department/division. We saw staff were visibly distressed if they thought a patient was not receiving good or appropriate EOLC. They believed the successes of the service were attributed to and a reflection of the whole team.
- A majority of SPCT at NPH had been in post less than a year and had not been party to the build-up of the merger with Ealing Hospital Trust to create LNWHT. Mergers can create uncertainty about the future of some services, however most of the SPCNs at NPH told us the merger had not caused them any concern and had noticed little difference apart from being part of something much bigger. We observed that there was some relationship building with their colleagues at Ealing Hospital, however this was in its infancy. One manager told us they were not sure whether their role would include managing the team at EH as well as NPH in the future. The lead nurse told us each hospital “had to get their own house in order” prior to the possibility

of full cross-site working. Other staff told us the geography made it very difficult to easily work across sites as none of the hospitals were easily accessible from one another and resulted in a lot of travelling.

- The senior leads told us there was a small move towards thinking about EOLC across the hospital but it was very much a work in progress. The SPCNs we spoke with had observed at ward level that there was a varied approach to EOLC. They observed that staff on specialist wards, such as critical care, were good at supporting patients and those close to them; and the consultants on the elderly care wards were "fairly good at looking after dying patients". However on the surgical wards the consultants may have recognised a patient is dying and request the palliative care support but continue "to actively and aggressively treat" the patient. One SPCN told us "they wanted me to convince the patient they were dying". We were also told that a surgeon said to a SPCN, "we don't believe in anyone dying, we want to save everyone." Other nurses told us there was a doctor-nurse divide when it came to EOLC. Confident nurses who recognised patients' who deteriorated were able to challenge consultants when it came to continuing aggressive treatment and continual observations; while less confident nurses were unable to do this, which meant the opportunity to discuss advanced care plans or the last days of life care agreement maybe lost.
- Staff reported an open culture where they could raise and discuss any concerns with their team and managers. The specialist nurses told us they were supported by their managers and department heads in all aspects of their work including training and supervision of their work.
- We observed a healthy environment where the SPCT were able to challenge and share their thoughts or opinions with each other. They said they werealso able to challenge, advise and support all clinical staff at ward level and gave us examples of how they have done this.
- The SPCNs told us theyperceived themselvesvalued by their managers and appreciated for how hard they worked. Staff were encouraged to manage their own workloads and have a degree of flexibility to allow them to support patients and complete paperwork without working longer hours than required. Regular MDT meetings about patients' needs and staff skill mix ensured that patients received the best possible response and staff were supported adequately to provide it.
- Staff had regular one to one meetings and clinical supervision where they could discuss concerns and any cases they had found emotionally difficult.

Public and staff engagement

- All the staff in the SPCT told us their opinion was valued andthat their thoughts and views were reflected in the planning of the service. For example the administrator for the team told us how they had made a suggestion at a MDT meeting in relation to a spreadsheet that was used. Their suggestion was taken on board and as a result data collection was easier.
- The SPCTs engaged with staff on the ward on a regular basis. Each of the SPCNs had sole responsibility for one ward. The aim was to increase this to two, however the SPCNs told us they did not have the capacity to support more than one ward yet as their workload was too great at this time. Staff we spoke with on the wards supported by a regular SPCN; knew who their lead was, and said they could approach them about any questions or help they needed with a dying patient. The SPCT spoke positively about the engagement they had with the ward staff and thought this had shown some increase in nursing staffs' understanding of palliative and EOLC. We were given example of ward staff actively recognising an issue relating to supporting patients at end of life due to a trend in reported incidents. They following it up with a request for support and training by the SPCT.
- The service found it was difficult to obtain formal feedback from patients as survey cards were rarely responded to. There had not been a patient survey for palliative or end of life care since our last inspection in August 2014. Staff spoke with patients on a one to one basis to obtain feedback about the service.
- There was patient representation on the EOLC strategy group to give the patients and their families a "voice" in discussions about the future strategy for EOLC across the trust.

Innovation, improvement and sustainability

- All staff in the SPCT, including nursing, medical, allied health professional within end of life services demonstrated a strong focus on improving the quality of care and people's experiences through a range of local

and national audits, pilots, surveys, feedback and teaching across the community setting. However we found that the acute and community services for Northwick Park and Central Middlesex hospital and community services for Ealing hospital were addressing the similar concerns with different projects. For example Brent and Harrow acute and hospice services were collaborating to develop a multidisciplinary education institute for palliative care. However at the time of our inspection the Ealing site had not yet been included. Ealing's Meadow House Hospice community palliative care team were developing an EOLC education programme for community nurses and GPs; and Northwick Park and Central Middlesex acute hospital were developing an EOLC e-learning training course for all staff to complete as part of their mandatory training.

- Undertaking advanced care planning in hospital was seen as the acute services taking the initiative and not leaving the responsibility solely to the community primary care services. This had an added benefit of building up relationships between the acute and the community services.
- The virtual ward in the community lead by a consultant from the acute palliative care extended working relationships with GPs and other acute clinicians to improve the health of patients with long term conditions and/or complex conditions, who may have frequent hospital admissions. Some of these patients may be in the last year of life. We were given an example of a patient who had been admitted to the hospital five times over the year and since being on the scheme their admissions to hospital had stopped.
- The joint working between acute and community was helping to develop and promote education in EOLC and provided patients with seamless support.

Outpatients and diagnostic imaging

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

Information about the service

Northwick Park Hospital provided 459,708 outpatient appointments between January and December 2014.

There is a centralised outpatients area with a main reception. Individual clinics are run in this area, with their own reception desks. The clinics held here included endocrine, infectious diseases, neurology, respiratory, vascular surgery, haematology, diabetes, phlebotomy, dermatology, urology, trauma and orthopaedics, general surgery and oncology. Other outpatient services are run and managed elsewhere in the hospital within their own divisions. These included radiology, cardiology, medicine, care of the elderly, obstetrics and midwifery and paediatric outpatient clinics.

During our inspection we visited the main outpatient area and visited the clinics for cardiology, haematology, dermatology, diabetes, orthopaedics and urology.

We spoke with 63 members of staff including receptionists, nursing staff, allied healthcare professionals such as radiographers, healthcare assistants, consultants, doctors, phlebotomists and administrators including the manager of the outpatients department. We spoke with 42 patients and four family members of patients.We looked at the patient environment, and observed waiting areas and clinics in operation and we looked at 35 sets of patient notes.

Summary of findings

Overall the safety of outpatients and diagnostic services at Northwick Park Hospital required improvement.

Outpatients services at Northwick Park Hospital did not consistently offer appointments within defined target times.

There was a good system in place to highlight which patients had waited longest and should be prioritised for the first available appointments. The trust had attempted to reduce the backlog of patients waiting for appointments, but financial constraints meant that additional clinics had been stopped.

We found that there were regular shortages of nursing staff in the outpatients departments and a shortage of consultants in radiology.

We found the method for tracking medical records was not reliable. Notes were stored in the medical records department and were collected by medical records staff in preparation for outpatient clinics. Notes had an electronic barcode tracking system for traceability. However, they were not always found because staff using notes did not always use the electronic barcode tracking system to sign records in or out of a department.

Outpatients and diagnostic imaging

Staff were not always aware of or have access to the incident reporting system through the electronic system including the duty of candour and the trust did not always correctly categorise incidents in line with trust incident reporting procedure.

We found limited evidence of the effectiveness of outpatient services and at times staff were not always caring or respectful of patients.

The services had begun to integrate across the three hospital sites following the merger in 2014, but progress was slow.

There was inconsistency between what the trust board and staff working in outpatient clinics told us.

We saw good evidence of how diagnostic services respond to patients' needs and how outpatients track the progress of patients on the waiting lists for appointments.

Are outpatient and diagnostic imaging services safe?

Good

Overall the safety of outpatient services at Northwick Park Hospital required improvement because systems and process were not robust enough to manage the risks to people who use services. There were regular shortages of planned staffing levels.

There were no reported never events relating to the outpatients or diagnostic departments at Northwick Park Hospital. Never events include wrong site surgery. However, we identified an incident which resulted in a patient being operated on because the diagnostic test results for two patients were mixed up.

There were 28 incidents categorised as outpatients between July 2014 and July 2015. One quarter of these related to health records. Medical records staff told us missing patient records were a daily occurrence and these were escalated through the incident reporting system. The method for ensuring medical records were available for clinics relied upon staff using the electronic tagging system to sign records in or out of a department and we found this was not reliable.

We found management of risks associated with emergency situations in some areas within outpatient services including haematology had not been appropriately recognised, assessed or managed. For example there were no clear evacuation plans for haematology and the evacuation plan for the outpatients department lacked sufficent detail to provide clear guidance for staff or patients.

We found medicines were not always stored or disposed of correctly, for example in haematology the fridge temperatures were not consistently monitored and unused controlled drugs were not disposed of in a traceable way.

Of the 63 staff we spoke with 16 were aware of safeguarding, 15 of them told us they were up to date with safeguarding training and a further four staff asked were unsure about the safeguarding process. We saw between 76% and 93% of staff had undertaken safeguarding training in the outpatients departments.

Outpatients and diagnostic imaging

We found there were regular shortages of nursing staff of up to 20% and a lack of consultant cover in some instances.

We were not assured all the outpatients departments had robust processes for recognising, assessing, or responding to emergency situations, for example situations requiring emergency evacuation.

Most of the staff we asked in radiology about the duty of candour knew what it was and one staff member described an example of when they had reported an incident requiring compliance with duty of candour requirements.

Areas visited were visibly clean and we saw equipment identified as clean through use of 'I'm clean' green stickers.

We reviewed recent reports from RPA inspection visits, IRMER inspections and general X-ray system performance and radiation protection reports. We did not identify any concerns from these.

Incidents

- There were 14 incidents relating to outpatients clinics from between July 2014 and July 2015; we identified a further 14 from other specialities relating to outpatient services. One quarter of these related to health records. For example, two sets of records were reported missing and not available in time for a clinic and five sets of misfiled records which contained information about more than one patient. The remaining incidents for outpatients included three delayed treatments due to long waiting times, two broken equipment (X-ray machine), two falls, two staff needlestick injuries, one lost biopsy, six inappropriate referrals or booking the wrong clinic, one interpreter not booked in time for an appointment, three incorrect prescribing or labelling and two related to abusive relatives of patients.
- We were concerned incidents were not always appropriately recognised, escalated or investigated and lessons learned were not widely shared.We were given inconsistent messages about learning from incidents. Some outpatient and some diagnostic services were able to describe learning from incidents and others told us they did not get feedback when things went wrong.
- We identified an incident whereby two patients' diagnostic test results had been mixed up resulting in one of them having unnecessary surgery to treat a suspected carcinoma.The trust investigated the incident and duty of candour was implemented to inform the patient of the error. This incident was not categorised by the trust as a never event although it fits the criteria outlined in the trust policy. We were not assured the gravity of incidents were appropriately reported in line with the duty of candour regulation and the trusts' own incident and near miss reporting policy. 12 out of 14 staff we asked knew what duty of candour was.
- A nurse told us that medical staff were not confident investigating incidents. We were satisfied that staff knew how to escalate incidents and these were investigated but we were not assured all outpatient and diagnostic staff were confident investigating incidents or that learning from them was widely shared.
- However , a nurse did describe an example when an incident occurred and was reported following a complaint. The outcome was that refresher training was given to a member of staff in the haematology department. Staff in the cardiac catheter laboratory told us of a medication incident which had been escalated but the staff had not received feedback about the learning from this incident.
- The medical records manager told us the Datix system prohibited use of personal identifier information which made investigating reportedly missing records unmanageable and reporting futile. We were not assured the Datix system was used to report missing records as frequently as this occurred or that learning from this type of incident was captured, monitored or shared.
- **Cleanliness, infection control and hygiene**
- Areas visited including the utility room in dermatology were visibly clean. We saw equipment identified as clean through use of 'I'm clean' green stickers in the ear, nose and throat clinic (ENT) and on the resuscitation trolley in the rheumatology department.
- Alcohol hand gel dispensers were available at entrances to outpatient clinics.
- Cleaning schedules were seen in outpatient area 5 and rheumatology clinic and had been signed as checked. The checklists in outpatient area 5 included checks for staff uniform and jewellery.
- We observed phlebotomy staff wearing personal protective clothing for example aprons and disposable gloves.
- We saw that clinical staff wore short sleeved uniforms in colours that denote their role. For example light blue for healthcare assistants, white for phlebotomists, dark blue for departmental sisters and dark red for matrons.

- We saw that the radiology department had undertaken a hand hygiene audit in March 2015. The results showed radiographers were 98% compliant; doctors were 96% compliant and nursing staff 100% compliant.

Environment and equipment

- Some of the facilities were not suitable to meet the needs of patients for example the haematology day care service. In the haematology day care treatment department there were five chairs in the room in a confined space lacking in privacy for patients. The waiting room was in need of repair; there was a badly patched hole on the outside wall where electric cables came into the department. Inspectors were concerned about the potential impact this had for the group of patients who may have had compromised immunity from infection.
- Two senior radiographers told us about frequent equipment failures resulting in delays completing and reporting diagnostic tests including CT scans. They told us about a trust programme of replacement of out of date equipment. We saw evidence of a business case for a replacement CT scanner.
- Theservice had an annual plan for audits in radiology, this included audits relating to IR(ME)R. Staff told us their next IR(ME)R audit was due to be done in February 2016.
- The IR(ME)R audit for Northwick Park Hospital on compliance with IR(ME)R report from March 2015 showed 'significant assurance' that the guidance relating to ionising radiation regulations were being followed. The report described compliance with IR(ME)R regulations as " demonstrated to be at a very high level" with only a few minor improvements necessary.
- We saw a copy of the trust radiology information system (RIS) and picture archive communication system (PACS) business case dated 22 August 2014. Staff in the radiology and IT support departments explained how the new system had been implemented.
- We saw in outpatient areas equipment was serviced, for example oxygen cylinders were appropriately secured, serviced and in date.
- We saw nasoscopes in the ear nose and throat clinic (ENT) were cleaned using Tristel wipes, which had been approved by the infection control lead nurse. One consultant expressed concern about the appropriateness of the cleaning of nasoscopes.
- Staff told us the resuscitation trolley in rheumatology was shared with other clinics including physiotherapy and occupational therapy and it was checked in rotation by each clinic.
- The resuscitation trolley in haematology was checked weekly. The record of checks was without gaps but on the day of our inspection, we removed an out of date inter-surgical airway and the nurse in charge re-checked the trolley.
- The resuscitation trolley in outpatients area 5 was clean, had been checked and there were no gaps in the record of checks.
- A disused shower room close to the haematology treatment area for outpatients was being used as storage and contained equipment including card board items, electrical equipment, bed bumpers and a large oxygen cylinder. We asked the clinical nurse manager about the area and she told us it had been recorded on the risk register. The risk register contained a general reference to lack of capacity within the outpatients department but we did not identify a specific risk or mitigating action for this area. We were concerned that the clutter and in particular the flammable items and oxygen cylinder posed a fire hazard.
- We asked for a copy of the emergency evacuation plan for the rheumatology area and were told this had not been updated. We did not receive a copy of a plan for this area. We were not assured this area had been appropriately risk assessed or the trust had an appropriate and safe procedure for ensuring fire risks were safely managed to protect patients from risk associated with emergency situations in the outpatient departments.

Medicines

- Medicines were seen to be correctly stored in rheumatology and dermatology and the fridge temperatures were regularly monitored and recorded.
- We found unused controlled drugs were not correctly disposed of in the haematology clinic. Staff told us they disposed of these in the yellow clinical waste bins used for needles.
- Cytotoxic spillage kits were available in the rheumatology clinic and we saw cytotoxic drugs were transported in prominently labelled packaging for safety.

Records

- We found the method for tracking medical records was not reliable. Notes were stored in the medical records department and were collected by medical records staff in preparation for outpatient clinics. Notes had an electronic barcode tracking system for traceability, however they were not always found because staff did not always use the tracking system to sign records in or out of a department.
- The medical records manager told us this was often because a clinic or department had borrowed the records to complete, for example the letter to be sent to the patient's General Practitioner (GP) but had not used the electronic system to sign them out.
- The medical records manager told us a temporary record was created when the main patient notes file could not be found. Main files and temporary patient records were held within the medical records department in separate areas. The medical records manager told us there were insufficient staff within the medical records department to amalgamate the temporary records into the main files.
- The medical records managers told us missing records were a daily occurrence and they used the Datix system to report missing or lost health records. We asked these managers to show us an example of reporting, however they were not able to access the Datix system.
- We saw evidence in the health records executive paper dated September 2015, analylis of the availability of records varied across the year between of 85% and 95%. We also saw analysis of creation of temporary case notes of between 500-900 per month.
- Medical records staff tried to ensure records were available in time for clinics. Staff told us they compiled a list of records the day before clinics.The medical records manager told us that medical records staff did not routinely check for temporary files which are stored separately when collecting a list of records in time for a clinic. He told us they do not have sufficient staff to merge temporary and main files as they compile clinic lists.
- A nurse told us the delay obtaining records had delayed one patient's treatment in the unit on the day we inspected.
- We looked at the records for 35 patients who attended an outpatient clinic at Northwick Park Hospital. All were legibly written, 14 sets of records identified allergy alert status and the treating physician signed 15 sets of records. Seven sets of notes had no outpatient information contained within them and eight sets of records had loose or incorrect documents. For example, one set of cardiology notes had no outpatient notes, but contained a sheet of dated paper.
- We observed records were placed in an unsecured consultation room in the diabetic clinic in anticipation of the clinic list for the day on 22 October. We asked a healthcare worker about this and were told patients' would not be able to access these inappropriately. We were not assured patient records were protected from the risks of inappropriate access and/or use or that patient confidentiality was not compromised.
- We were not assured records were always accurate or available in time for outpatient clinic appointments.

Safeguarding

- Information provided showed 93.2% of staff required to undertake safeguarding adults training Level 1 had completed this training and 76.7% of staff required to undertake safeguarding adults training level 2 had completed this.
- Information provided showed 82% of staff required to undertake safeguarding children Level 1 had completed this and 75.6% of staff required to undertake safeguarding children training Level 2 had completed this training.
- We spoke to13 staff, eight of whom understood and could describe a safeguarding concern, four were unsure and all of them told us they had received safeguarding training.
- One member of radiology staff described an example when a safeguarding concern had been escalated.
- We did not see any chaperone posters in the diabetic or ear, nose and throat (ENT) clinic areasand asked staff if chaperones were provided. The sister told us that consultants ask patients if they want a chaperone.
- We saw a chaperone poster displayed in different languages in the main outpatients area.

Mandatory training

- The trust target for integrated clinical services teams' completion of mandatory training was above75%. We believed this to be an unambitious target.
- Mandatory training for this trust included equality, diversity and human rights; fire safety; health & safety;

major incident awareness; infection control; manual handling level 1 and Level 2; Mental Capacity Act Level 1 and prevention of terrorism known locally as prevent; and information governance.

- Outpatients staff had completed training as follows: equality, diversity and human rights 83%, fire safety 73.4%, health & safety 92.6%, major incident awareness 57.8%, infection control clinical 57.8% (non-clinical 91%), manual handling Level 1 85.7% and Level 2 86.%, Mental Capacity Act Level 1 78.3% and prevention of terrorism known locally as 'prevent' 51.9% and information governance 80.4%.
- Radiology outpatients staff had completed training as follows: equality diversity and human rights 67%, fire safety 74.6%, health & safety 80.4%, major incident awareness 35%, infection control 61.9%, manual handling level 1 56.5%, Mental Capacity Act Level 1 60%, prevention of terrorism known locally as prevent 38% and information governance 54.4%.
- Ten staff told us they were up to date with all the required mandatory training. Three members of staff told us there were gaps in thier mandatory training completion, citing face to face training was more difficult to attend owing to clinical comittments.

Assessing and responding to patient risk

- Radiology services had access to a radiation protection advisor at St George's hospital and were last risk assessed by the radiological protection advisors in April and December 2014. The December 2014 report showed that nuclear medicine and radioisotope audits were up to date and there were no reported radiation incidents.
- A risk assessment for the radiology department showed risks around long term (25 years) follow up mammography appointments had been identified, classified according to severity and an action plan developed to respond to the most urgent risks. For example, the actions identified to address the potential problems of out of date personal information included, development of a long term procedures database and appointment of a breast service manager.
- Staff in the plaster room told us a risk assessment was carried out and a recommendation was made to purchase a saw with a vacuum attached to reduce dust in the air.
- Rheumatology staff told us they assess patients within close proximity of seating to prevent patients collapsing.
- The layout of some clinics did not always make management of deteriorating patients safe. For example, the haematology treatment area was not always sufficient to support the numbers of patients receiving treatment and patients were then accommodated in the patient and relatives waiting room. This room was not suitable for immunocompromised patients and had limited opportunity for staff to observe and or communicate with patients receiving treatment.
- The outpatient sister told us the anti-coagulation service was provided from within the current phlebotomy service and test results were posted to patients. We were told there was a plan to provide an anti-coagulation clinic separately. We asked for a copy of this plan. We did not receive evidence of this plan.
- We were concerned delays in adjusting anti-coagulant medicines whilst patients wait for test results in the post did not protect patients from the potential of unnecessary harm. We did not see evidence of a risk assessment for anti-coagulant medicines.

Nursing staffing

- Staffing data showed, since January 2015, there were shortages of nursing staff of between 7.8 and 10.1 whole time equivalents (WTE) in the outpatients department every month. This is equal to 15% to 20% of the staffing establishment.
- The outpatients manager told us agency staff were not used. We were told that not all outpatients staff were substantive, 10 wte staff were bank staff.
- We were told that there were 189 WTE staff in outpatients including nursing staff but, excluding those from the specialities who run their own clinics.
- The manager for the chemotherapy outpatient service told us the service was fully staffed, with few vacancies and on the day we visited the service we saw the rota and this indicated five qualified and one healthcare support worker on shift.
- A senior nurse in haematology told us they shared staff with the in-patient service and, although there were vacancies, these did not affect the outpatient service. The senior nurse told us typically there were three qualified and one unqualified nurse staffing the outpatient service and they used bank staff but not agency.

Outpatients and diagnostic imaging

- The nurse in charge of outpatients told us that the new matron had made positive changes. For example, by ensuring the skill mix did not include staff deployed inappropriately from other departments with injuries such as a broken arm.
- The outpatient sister told us recruitment was a challenge and, more recently, the appointment of a matron had provided additional support including for drafting a business case for a separately staffed anti-coagulation clinic. We asked to see the business case for this initiative, but did not receive any information which demonstrated this plan had the backing of the trust board.
- During the inspection we identified staffing shortfalls in general surgery and respiratory outpatient departments.. The respiratory clinic was short of two consultants who were off sick and two registrars had been sent from other departments to help; there were normally two respiratory technicians, we were told one recently retired and the second was on sick leave.
- The general manager for outpatients told us of the creation of a new flexible band 3 role providing a mixture of a healthcare assistant and administrative support. She told us staffemployed in this role could move between departments and responsibilities to respond to urgent need.
- The outpatient sister told us that the matron had stopped occupational health staff from sending staff with temporary injuries including broken limbs from other departments to work in outpatients departments.
- We were told by the radiology manager recruitment was a challenge and they tried to retain staff by promoting and supporting higher education. For example, for band 5 staff to become band 6. She told us this worked well to a degree but then could cause skills gaps and a rolling programme of recruitment had been considered to minimise vacancies.
- We saw evidence in the rotas of regular gaps due to staff sickness in radiology and other team members working overtime had covered these.

Medical staffing

- During the inspection we identified staffing shortage in general surgery. On the 20 October, two of the three scheduled consultants were off sick and two registrars had been sent to the department to assist the clinics.
- The assistant director of nursing told us there were no medical personnel directly employed for outpatients. Medical staffing is provided by the specialities. For example in haematology, a senior doctor told us there were seven consultants, seven registrars and four junior doctors and two of the doctors covered outpatient appointments.
- We saw evidence of recruitment of two consultants in haematology.
- The pre-inspection information identified some concerns around consultant cover in haematology. We spoke with a specialist registrar in haematology and he told us:"this is a notoriously busy job". He also told us that consultants were supportive and teaching sessions happened on four mornings weekly.
- Three senior managers told us additional clinics had been booked to deal with a backlog of patients waiting for outpatient appointments. We were told dermatology had included additional clinics on a Saturday, but were unable to corroborate this.

Major incident awareness and training

- We saw staff were required to complete anti-terrorism and major incident awareness training. Information provided by the trust showed around 58% of outpatients and 35% of radiology staff had completed major incident awareness training. This information showed that 52% of outpatients and 38% of radiology staff had completed anti-terrorism training.
- The major incident plan located in the accident and emergency radiology department was dated 2012 and did not have a review date.
- The trust had a business continuity plan dated January 2015.None of the staff we spoke with mentioned this plan. However, the plan included a flow chart to cascade information between other relevant parties should a disruptive incident occur such as loss of electricity supply.

Are outpatient and diagnostic imaging services effective?

Requires improvement

Overall we found diagnostic and outpatient services could provide limited assurance of their effectiveness because services were using different processes and systems, there was a lack of a coherent strategy for monitoring outpatient services to provide evidence of best practice.

Outpatients and diagnostic imaging

We saw some services, for example cardiology, haematology and radiology, worked to national and or local guidelines.

In practice, the three hospital outpatient departments remained separate and each of these had different systems and processes for providing outpatient services from the speciality led clinics.

Evidence-based care and treatment

- We saw the trust had a priority audit list for 2015/2016 for the integrated clinical services division which encompassed outpatients. The list included radiology audits but there was limited scheduled activity specific to outpatients at Northwick Park Hospital. This included an audit entitled 'A snapshot audit of compliance with internal standards of pharmacists checking the allergy status of patients on all out-patient prescriptions and Appropriateness of Outpatient Prescribing'. We did not see any examples of completed outpatient audit activity.
- We saw evidence of the use of NICE guidelines for example, in the diagnosis of colorectal cancer (CG131), were not consistently followed which resulted in delayed diagnosis and treatment for one patient.
- The clinical nurse specialist in diabetic clinic told us they use NICE clinical guideline CG 15 for treatment of type 1 diabetes.
- The radiology department provided 35 examples of audit activity undertaken against local or national guidelines including against the Royal College of Radiologist and National Patient Safety Agency guidelines (NPSA) checklist to prevent wrong site surgery and or to prevent inadvertent retention of instruments or invasive equipment within the patient in 2014.
- The radiology service carried out re-audit in January 2015 of nuclear medicine adult doses in compliance with the trust guidelines based on NICE guidance. The results showed that most doses were within expected levels and none of the exceeded doses were reportable under Ionising Radiation (Medical Exposure) Regulations 2000 (IRMER).
- We saw that the radiology service carried out audits of awareness of radiation doses in diagnostic radiology in 2011 in year 5 ICSM medical students and re-audited this in 2015.The results showed knowledge was poor and a recommendation was made to introduce an IR(ME)R style lecture at module induction.
- We saw evidence of use of best practice guidelines in the haematology clinic and the cardiology clinics for echo-cardiogram (ECG) which followed Department of Health guidelines for intrathecal care and the British Society of Echocardiography protocols. There were hard and electronic copies of these guidelines available with the clinic.
- The radiology department audited the paediatric computerised tomography (CT) doses in February 2015. The results varied according to the machine being used, older equipment showed higher doses and a recommendation was proposed to use the more reliable newer scanner for paediatric patients' diagnostic tests.
- The radiology department had audited the condition, safe storage and availability of personal protective clothing (PPC) last year and re-audited in January 2015 in response to shortage and damaged PPC. The results showed almost half the gowns were damaged making them unusable.A recommendation was made to correctly store gowns to minimise future damage and or unintended radiation exposure.
- We saw results of an audit of patient identification and adoption of a local standard of using three patient identifiable criteria. The original results from 2005 showed a 54% rate of checking three forms of identity. We saw this audit had been repeated annually since 2005 and had shown an improvement in compliance to 70% with the three identifiable criteria by 2014.
- We saw from the NHS England national peer review programme based on NICE guidance the trust participated in the London Cancer Alliance and participated in a number of trials including screening for myloma and lymphoma.The national peer review studies are a mixture of self-assessment of a range of cancers and external peer review visits and the most recent reports from 2012-2013 showed self-assessment of head and neck, speciality skin, upper gastrointestinal (GI) and colorectal cancers were in three out of the four backed up by peer review visits and one peer review visit assessed the trust at 78% versus their own assessment of 91%.

Pain relief

- There was no pain management clinic at Northwick Park Hospital. We were told the trust wide pain management clinic is held at the Central Middlesex Hospital.
- We saw evidence in two sets of notes in the chemotherapy clinic that pain relief had been considered and or offered to patients.
- Rheumatology staff told us patients were advised to take paracetamol in the first instance or make an appointment with their GP if this did not alleviate their pain. They also advised patients to stay as mobile as possible. We were told that there are patient forums, but, as these were patient led, there was no information to support this.
- We spoke with 63 patients and four family members, none of them raised pain relief as a concern.

Patient outcomes

- We did not see evidence of outpatient department audit or service monitoring for improvements.
- We did not see information about participation by the trust in accreditation schemes including the Imaging Services Accreditation Scheme (ISAS).
- We did not see information about participation by the trust in accreditation schemes, for example the Improving Quality in Physiological Services (IQIPS) accreditation scheme for audiology.

Competent staff

- The lead chemotherapy nurse told us staff were competency assessed, for example, using the London cancer awareness tool, and were recruited as experienced band 6 nurses who had done or were willing to undertake specialist training in chemotherapy. We saw evidence of one member of staff's additional training.
- The radiology manager told us they work with the University of Hertfordshire who send students to the trust and many of the graduates stay. We saw in the radiation protection advisor's report February 2015, staff had been IRMER trained, there were annual updates and further on-line radiation protection training was available through the radiation protection advisor and supervisor.
- We were told the lead radiographer had advanced training in CT reporting, but was often not able to carry out this work owing to staff shortages.
- The radiology manager told us there was a national recruitment problem and they supported training of band 5 radiologists to enable promotion within the trust but this then leftes a gap in band 5 staff.
- Information provided showed 92% of outpatients staff and 64% of radiology outpatient staff had an up to date appraisal.
- Revalidation of doctors' information was provided for the whole trust. This information showed there were 433 doctors requiring revalidation across the trust. It was not possible to tell from this information which of the 69 doctors' revalidation had been deferred pending more information or the three fitness to practice panels related to medical staff practising within the outpatient departments.
- Eleven staff we spoke with told us they had good training opportunities and two staff told us they had been encouraged to gain additional qualifications through retraining to become qualified staff. For example, a healthcare assistant in the dermatology clinic told us the trust would support retraining to become a registered general nurse.

Multidisciplinary working

- In practice, the three hospital outpatient departments remained separate and each of these had different systems and processes for providing outpatient services from the speciality led clinics.
- We attended a multidisciplinary haematology meeting during our inspection. This meeting was well attended by a mixture of three senior nurses, two junior medical staff and seven senior medical staff. Discussions took place respectfully and the consultant chairing this meeting updated patient information.
- Radiology staff told us they worked across the sites, but told us the processes were not standardised.
- We saw evidence of internal multi-disciplinary (MDT) working for example between specialities and with allied healthcare professionals (AHP's). For example, we attended a multidisciplinary meeting in haematology which was attended by doctors from different specialities, nurse specialists and a consultant radiologist.

Seven-day services

- Outpatient therapy services including physiotherapy were provided seven days a week.

- The radiology manager told us diagnostic services staff had begun to function as an integrated team and worked across the three trust hospital sites. They had changed their working patterns to cover on-call working for evenings and weekends.
- Magnetic resonance imaging (MRI) and CT scanning was provided between 08:00 to 20:00 seven days a week.
- We did not identify any outpatients clinics which were provided beyond normal working hours.
- However, we were told that the diabetic clinic had invested in new technology that allowed clinicians and patients remote access to information about patients' illness which helped plan treatment. For example through use of email and or texting.

Access to information

- We saw evidence that the time taken to answer telephone calls to the booking service was monitored between April and July 2015 and that the average call processing time was less than two minutes.
- Five managers told us missing records do sometimes cause problems and resulted in not all patients' information being available in time for clinics.
- We were told that medical records had not been a priority for investment until six months ago and that the service lacked resources to for example to amalgamate temporary and main files or expand the space available for storage of records.
- We were given contradictory information about the availability and use of clinic letters. The outpatients service manager told us these were available electronically but not used. One consultant told us he used the electronic system to access previous clinic letters.
- The patient records programme manager told us the board had reviewed a three phase plan to unify patient records processes starting by unifying the hard copy notes and ending with implementation of an electronic patient records system. He showed us a copy of the phased plan which had been presented to the board in September 2015.
- The IT department staff told us about problems which had been identified earlier in the year when a new radiology information system (RIS) was implemented as part of the implementation of the business case above and which had caused a backlog because staff were unfamiliar with the new programme and took longer to complete tasks.
- A senior radiology manager told us the backlog often prevented them from reporting results in real time and their goal was to eliminate the backlog and report results in real time. The radiology manager told us there remained a backlog of approximately 2400 test results and results were reported within 24 hours.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information provided showed the trust provided Mental Capacity Act Level 1 training to staff and 78.2% of outpatient staff and 62% radiology staff were up to date with this training.
- Ten staff told us they were up to date with mandatory training which included dementia awareness and Mental Capacity Act training. One member of staff in the radiology, rheumatology, phlebotomy, oncology, outpatients area and dietetics departments told us how they supported people with learning difficulties including prioritising them for treatment upon arrival.
- We did not see evidence of reduced capacity or of mental capacity assessments in the notes we looked at.
- We identified consent was not always fully completed in haematology notes. We looked at nine sets of patient records in haematology and in four sets of these notes, consent was not accurately completed. For example, doctors' signatures were not always present or legible.
- We saw in use in the radiology department an adapted version of the WHO checklist for surgery was used. The world health organisation (WHO) checklist included consent as part of the pre-surgery checks.

Are outpatient and diagnostic imaging services caring?

Good

We rated caring as requires improvement because we found patients were not always treated with dignity, kindness or respect at Northwick Park Hospital outpatients department.

On three separate occasions we observed outpatient staff being rude or unkind to patients. Two patients told us outpatient staff had a bad attitude.

Friends and family test information for August 2015 showed 91.54% of respondents would recommend the outpatients

services at Northwick Park hospital.However, the total number of respondents was less than 3% (1608) of patients seen last year and may not be a reliable measure of patient satisfaction with outpatient services.

We did not observe any method for informing patients of waiting times or delays.

The trust scored better than the national average for 'Family definitely given all information needed to help care at home' at 65% against a national average of 60% in the national patient survey.

Compassionate care

- During our inspection we mostly observed staff interact positively with patients and 18 patients we spoke to told us staff were kind or respectful.
- One diabetic patient told us her care was very good particularly when she had been pregnant. This patient described her care by the diabetic clinic as "outstanding".
- Three patients told us staff in ENT and fracture clinic had a bad attitude. On three separate occasions we observed outpatient staff being rude or unkind to patients.
- The first time, we observed a member of fracture clinic reception staff being rude to a patient who had made a mistake with her appointment day and time. We observed this member of staff mocking the patient when she turned away from the reception desk. However, this member of staff realised we had observed this interaction and was subsequently seen helpfully guiding the patient to the correct area for her treatment.
- On the second occasion, we observed clinical staff ignoring patients waiting to check in for their ear, nose and throat clinic (ENT) appointments. We witnessed three patients, some of who were using walking aids, waiting for an absent receptionist in clear sight of three nursing staff having a conversation. The nurses did not intervene in the absence of the receptionist. A patient approached us and we requested the nursing staff respond to the waiting patients. The receptionist returned but dealt with the waiting patients without apology or courtesy. The most senior of these nurses walked away without helping the patients or reprimanding the receptionist.
- On the third occasion, we observed an administrator entered a rheumatology consultation room without knocking or apologising to the patient, handed the consultant a document, exited and slammed the door without an explanation for the interruption.
- Staff told us they would ensure patients with particular vulnerabilities such as dementia or learning difficulties would be prioritised and seen upon arrival in clinic to minimise anxiety.
- Friends and family test information for August 2015 showed 91.54% of respondents would recommend the outpatients services at Northwick Park hospital. However, the total number of respondents was less than 3% (1608) of patients seen last year.
- The results for individual outpatient services varied. For example phlebotomy scored 70.37% (27); dermatology 93.88% (98) and the breast clinic scored 89.55% (201).
- One patient in fracture clinic and one patient in ENT told us it was difficult to keep children occupied when waiting times were long and there was nothing for them to do.
- Some outpatient areas did not provide privacy for patients owing to lack of space.For example, in haematology day care or in consulting rooms and in maxillo facial outpatients there were glass panels in the doors to the consulting rooms.

Understanding and involvement of patients and those close to them

- Three patients in the cardiology clinic said about their treatment: "very happy, all well explained"; "brilliant" or "everything was fine".
- One patient in orthopaedic clinic and anther in the diabetic clinic told us "staff go the extra mile" to give them the best treatment.
- We observed phlebotomists interacting with patients in a positive caring manner to check their health status and if there had been changes in this.
- Results of the national cancer patient survey 2014 showed the trust performed less well than the national average for 'clear written information about what patients should / should not do post discharge'. The trust scored 82% against a national average of 85%.
- In the same survey the trust scored better than the national average for 'Family definitely given all information needed to help care at home' at 65% against a national average of 60%.

Outpatients and diagnostic imaging

Emotional support

- Results of the national cancer patient survey 2014 showed the trust scored 84% for 'Patientbeing told sensitively that they had cancer' and 70% for 'Patient told they could bring a friend when first told they had cancer'.
- The sisterin the outpatients department told us there were sometimes delays transporting patients by ambulance at the close of clinics and the staff would stay with the patient until transport or transfer to a discharge lounge had beenarranged.
- During our inspection the fire alarm sounded. There was confusion among staff and patients as to the need to evacuate the area. We observed one manager reassure staff. We did not see or hear staff trying to reassure patients the risk was contained within the accident department or that there was no need to evacuate the outpatient department.

Are outpatient and diagnostic imaging services responsive?

Good

We rated responsive for outpatients and diagnostic imaging as requires improvement. We found that some aspects of the outpatients and diagnostic services at Northwick Park Hospital were good.For example the outpatients manager had access to the waiting times for all clinics and there was a system in place which attempted to ensure 95% of patients were given an appointment within an 18-week period from referral.However, theservice was not meeting this referral to treatmentstandard.

There had been a 39% surge in demand for outpatient services across the trust. The 'did not attend' (DNA) rates for the trust were high. The trust trialled using text messages to remind patients of their appointments and to try to reduce the DNA rate. The trust had not attempted to find out why patients did not attend their appointments. We found some services had offered evening and weekend appointments.However we were told these would cease from next month owing to financial constraints.

Service planning and delivery to meet the needs of local people

- Patients referred to outpatients at Northwick Park Hospital could choose to attend outpatients there or at one of the two other hospitals run by this trust, Ealing Hospital or Central Middlesex Hospital. Patients with urgent needs, for example two-week wait cancer patients, were given the first available appointment regardless of location.
- Outpatients and diagnostics services were provided from a mixture of new and older less suitable facilities. For example, the haematology day care unit was located in an area which was cramped and in need of some repairs. The radiology service in the accident department was contrastingly new and modern.
- Signage for outpatient clinics was in some cases poor and or stopped short of providing clear directions for patients. For example, for blood testing and dermatology signage was poor. A staff member told us they had raised concerns about poor signage before a previous CQC visit, but nothing had changed.
- There had been a 39% surge in demand for outpatient services across the trust.
- The trust had high did not attend (DNA) rates of between 5.5% for oncology and 20% for respiratory medicine. The trust had trialled using text messages to remind patients of their appointments and to try to reduce the DNA rate. The chief executive and the outpatients general manager told us about the pilot. Staff in the out-patients booking department told us the text pilot didn't work and had been stopped. We asked to see the evaluation evidence for the text pilot. The trust told us they had not completed an evaluation of the pilot.
- There was no dedicated anti-coagulation clinic for patients on blood thinning medications. Patients receiving blood thinning medication require regular check-ups to ensure the medication was adjusted to manage unintended side effects of this type of medication. Patients requiring blood tests for this medication had to attend the phlebotomy service. Test results were sent to patients by post, which was not always reliable and had caused delay for patients who required changed doses of blood thinning medication.
- The phlebotomy service was a walk-in service, with a ticket machine to ensure patients were seen in order of attendance. Four patients and two relatives of phlebotomy patients with whom we spoke told us they often have to wait up to one hour for blood tests.

Outpatients and diagnostic imaging

- We visited the phlebotomy service on 20 October 2015. There were five phlebotomists working in the department at the time of our visit. One patient commented there had usually been only two or three and the service had been quicker today. This patient also told us the service had deteriorated since the trust merged late last year.
- The cardiology wards, coronary care unit, catheter laboratory, physiology, cardiology outpatients clinic and the day care unit were closely situated within the cardiology department. These areas were spacious and included facilities for teaching and research as well as patient care.
- The rheumatology clinic space was cramped, resulting in a lack of patient privacy. We were told two bed bays had been removed to provide five chairs for treating patients. A patient in this area told us he was treated in the relatives' waiting room when there were no chairs available in the treatment area.
- The phlebotomy clinic was cramped and contained five chairs which were separated only by disposable curtains. This offered limited privacy for patients.
- We saw the gymnasium area within the physiotherapy service was overcrowded. The outpatient therapy services manager told us space and out of date equipment were challenging.
- We asked the outpatient booking staff if an attempt had been made to understand why patients did not attend their appointment. They told us no attempt had been made to find out the reason for non-attendance.

Access and flow

- The trust had a backlog across the board of patients being referred for outpatient treatment. Hospital data showed 2763 patients across all specialities were waiting more than 18 weeks for an appointment.
- The percentage of patients waiting over 18 weeks for treatment (June 2015) ranged from the lowest in urology (8.2%) followed by gastroenterology (8.3%); colorectal surgery (11.9%); respiratory medicine (13.0%) with the highest percentage in general surgery at 14.6%.Service managers for surgery and urology told us extra clinics had been offered to address the backlog, but these would cease in November 2015 due to financial pressures.
- Rheumatology staff told us they assess patients within close proximity of seating to prevent patients collapsing.
- Rhuematology staff told us there were nine patients who had waited more than 18-weeks for an appointment, they had been offered treatment at Ealing hospital instead and five patients had accepted.
- The cardiology delivery manager told us patients waiting beyond the 18-week target were often delayed waiting for tests. They had not analysed this. Cardiology clinicians were looking at which patients test results were normal and did not require a follow up appointment to help manage the waiting list when extra clinics were stopped.
- The maxillo facial divisional manager told us patients were prepared to wait through choice rather than pay for example, for complex dental treatment in the community. Attempts had also been made to change the referal criteria as some procedures could be treated in the community were more expensive to carry out in a hospital. New referal guidelines were implemented in April 2015, but had not changed referal patterns.
- Over half of the requested diagnostic tests were for non-obstetric ultrasoundand patients waited the longest for these. We saw evidence that no patients waited more than six weeks for a radiological diagnostic test.
- Outpatients services were part of the divisions of integrated clinical services, surgery, medicine and women and children within the trust. The trust had consistently failed to meet the 95% target of patients referred to treatment within 18 weeks within the divisions of surgery and medicine. Information on the trust divisional performance scorecard showed that year to date (July 2015) the trust had achieved 92.04% for surgery and 93.88% for medicine.
- Diagnostic services performed better at 99.17% within 6 weeks. However, the radiology service manager told us there remained a backlog of approximately 2400 test reports.
- The introduction of a new IT system for diagnostic testing including radiology in June 2015 resulted in a backlog of patients waiting for tests and an increased need for manual validation of electronic data. This was a large project owing to the number of different and incompatible IT systems in use across the three hospital sites.

Outpatients and diagnostic imaging

- The radiology managertold us the backlog was reducing daily. However, the September minutesof the clinical radiology consultants meeting identified an increase in the backlog. The minutes did not state what the backlog was.
- Radiology staff changed their normal working pattern to be able to open radiology between 8am and 8pm as part of the measures to reduce the resulting backlog caused by implementation of the new IT system. The trust stated that itwas also to provide a service that's helps working people to attend for x-rays and scans outside normal working hours.
- The general manager covering the maxillo-facial service told us they also offered evening outpatient appointments on one evening per week.
- Not all outpatient appointments are managed by the outpatients department team. However the medical records manager has access to information about all outpatient referrals and there was a system in place which ensured specialities who manage their own clinics are made aware of patients who have waited close to 18 weeks.
- We spoke to four patients and two relatives of patients in the phlebotomy service. They told us the waiting times once they have arrived in the department are often up to one hour. We spoke with 38 patients at other outpatient clinics throughout the hospital and nine of them told us they often waited up to one hour. We were told the trust did not audit waiting times.
- Echocardiography clinic offered a limited number of echocardiography outpatient appointments out of normal business hours service by one sonographer who works late on weekdays. Patients told us they waited up to five months for an echocardiography outpatient appointment.
- Theservice had a patient access guideline which referred to the national two week maximum waiting target for appointments for patients who required treatment of malignant disease. We saw that the divisions monitored the achievement of two-week referrals on a monthly basis and in July 2015 the divisions were achieving the following: integrated clinical services 98.9%; Women and children 96.5%; Medicine 93.8% and surgery 91.4% of patients' were given an appointment within two weeks.
- The outpatients manager told us the trust had a regular cross-site weekly meeting to discuss the numbers of patients waiting close to the 18-week target to ensure these patients were given an appointment within the target. We found this meeting had been cancelled the previous week and the week during the inspection.
- The trust prioritised appointments for life limiting illnesses for example suspected cancer. Medical records staff told us how they ensured two-week wait suspected cancer patients were fast-tracked.

Meeting people's individual needs

- The outpatients general manager and three outpatient staff told us they had telephone access via 'pink' telephones for people requiring translation services.
- We saw poster information offering chaperones in different languages within the outpatient department.
- One outpatient receptionist and the sister in outpatients told us patients living with dementia or patients with a learning disability were seen more quickly to avoid them having to wait and to minimise anxiety.
- We were told that rheumatology used biosimilar drugs and pre-mixed these to prevent patients waiting for long periods. One patient told us their medication was 'always ready when they arrive' for treatment.
- We found chaperones were offered and information about this was available in other languages throughout the outpatient department.
- Results of the national cancer patient survey 2014 showed the trust performs less well than the national average for 'clear written information about what should / should not do post discharge'.
- Surgical staff told us patients had been admitted to the Surgical Assessment Unit on Fletcher Ward when they did not meet the criteria, with a National Early Warning Score (NEWS) above two. Subsequently they were reported to be left waiting in chairs.Further, once the patient was on the ward, they were considered an inpatient and hence there was difficulty in accessing diagnostic services.
- There was nothing to occupy patients waiting for treatment in outpatients, for example magazines, radio, WiFi or television.

Learning from complaints and concerns

- The trust had a complaints and concerns policy. We saw a copy dated October 2014 and this policy had been updated to take account of the Francis enquiry recommendations. The chief executive told us there had been a new complaints policy implemented.

Outpatients and diagnostic imaging

- The complaints procedure flow chart provided by the trust showed complaints should be logged on the Datix incident reporting system.
- Two members of the staff we spoke with in phlebotomy were aware of complaints and described complaints which had occurred in the department. They did not mention the new policy or procedure and they did not describe completing a Datix for a complaint.
- We asked the trust for a breakdown of complaint information relating to outpatients departments. We received information about complaints for outpatients and in-patients. This information showed there had been six complaints in relation to outpatient services at Northwick Park Hospital. The most complained about service was trauma and orthopaedics (37). We identified four of these related to outpatient services.
- There were 13 complaints about ENT outpatients, five of these related to staff attitude and the rest related to delays and cancellations of treatment.
- The phlebotomy manager described how a patient complaint about rude staff had been shared through a team meeting and the individual had been retrained in customer care.
- We saw evidence in the trust information that there were seven complaints about haematology outpatient services. The complaints related to delayed diagnosis or treatment (four),waiting times for an appointment (two) and one regarding a leaking infusion bag. The trust information showed five complaints have been closed, but no information was included about how they were resolved.
- Seven of the patients we spoke with in outpatients told us parking was difficult or expensive. The trust website contained information about parking charges. Daily charges varied between £2.50 and £12.10. It was possible to buy a five or seven day pass if needed at a cost of £22.50 or £28.50. Dialysis patients could park in a designated car park all day for £2.

Are outpatient and diagnostic imaging services well-led?

Good

Overall we found the leadership of outpatient and diagnostic services required improvement because governance processes and systems lacked clarity and or integration to support a learning and innovative culture.

The trust missed the opportunity presented by the merger to assess the skill mix and structures for managing outpatient services including medical records and booking services. The trust had recently identified more work was required to streamline processes and had begun to identify key roles and responsibilities.

We found there was a lack of a well-considered strategy with key staff allocated and clear timeframes for achievement for outpatient services at Northwick Park Hospital.

We found outpatients had good local leadership for example in the diabetic clinic,radiologyand chemotherapy.

Four divisions shared accountability for outpatient services and the governance processes were underdeveloped. The trust was in both the top and bottom 20% in the NHS staff survey results 2014 in various areas.

Vision and strategy for this service

- The trust had a draft clinical strategy dated September 2015. The document lacked detail including time frames for work to achieve the trust goals. This document made limited reference to the challenges faced by outpatient services.
- The trust was formed in 2014 after merging with Ealing Hospital and the outpatient directorate had a draft service delivery plan for 2015/16. The draft plan had stated quality improvements would be required including merging booking centre teams across all three acute hospitals and community to create a one stop Patient Access Centre for all patients, reducing DNAs by texting service and develop an emailing system to reduce paper and postage costs. The divisional general manager, the divisional lead nurse and the general

manager were named as the responsible leads for the plan. At the time of our inspection the booking centre had not been merged, the DNA rate remained high and plans to reduce paper costs had not been started.

- The trust had an information management and technology (M&T) Strategy dated June 2015 led by the director of information technology (IT). The strategy confirmed the trust board had agreed in principle in March 2015 to implement a single digital record keeping system but not when they would do this.
- The trust had a divisional business plan 2015-16 led by the divisional clinical director. The divisional lead nurse and the general manager have contributed to this plan, but not the director of IT. The plan referenced the challenges faced by poor IT infrastructure, but there was no specific detail of how these would be addressed.
- There was inconsistency between what the board leaders told us and the perception of operational staff in clinics. For example, the chief executive told us about the text pilot to remind patients of their outpatients appointments and the new complaints procedure. We found some outpatient staff believed the text pilot was discontinued owing to financial pressures.

Governance, risk management and quality measurement

- Outpatients was managed within the integrated clinical services division. Some specialities managed and arranged their own outpatient clinics within divisions of surgery, medicine or women and children's' services. This meant the four separate divisions shared accountability for outpatients services. The trust had a performance monitoring scorecard based on the four divisions.
- We were given a copy of the Northwick Park Hospital 'New KPI dashboard' dated April 2014. The dashboard was in a spreadsheet format which aspires to record the number of equipment audits, MRSA screening reviews, nutrition audit forms and NEWS reviews amongst other data which would be more relevant in a ward based than outpatient setting.There was no data recorded on this spreadsheet in relation to any of the identified KPI's.
- We were given a copy of the divisional performance scorecard dated 2015. This showed outpatients data was recorded both within the integrated clinical services division and within the other three divisions.Outpatient information was reported under the speciality and included the number of hospital appointments, attendances, cancellations, DNA rate for both new and follow up appointments.
- We found some outpatient and diagnostic services had regular multi-disciplinary meetings where risks and incident reporting were on the agenda. For example, radiology consultants meet monthly and the executive lead for radiology and the cross-site general manager attended the meetings for July and September 2015.
- The radiology consultants' minutes recorded some discussions which had taken place. However, action points were mostly blank for June and July, but completed in September. There was a lack of continuity in these meetings, for example the June minutes recorded that the duty of candour had been raised by one of the consultants, but this was not followed up at the July or September meeting.
- We saw the trust radiation protection committee met in December 2014 and September 2015 and key risks were discussed. This meeting was cross-site and included staff from Northwick Park and Central Middlesex hospitals. Ealing Hospital held a separate meeting in June 2014 and minutes of this meeting were attached to the minutes for the September 2015 meeting. There was a radiology incident reporting spreadsheet which showed there had been 100 radiology incidents both within in-patients and outpatients between January 2014 and August 2015.
- Minutes of the September 2015 meeting included a separate list of incidents for Ealing Hospital and which were recorded in a different way from those at Northwick Park Hospital. The outpatient department incident spreadsheet included MRI scanning errors but no other diagnostic incidents.
- There were gaps in monitoring information to improve the service. For example we were told about a pilot text project to reduce the number of patients who did not attend (DNA).We asked staff about the reasons for non-attendance for outpatient appointments and were told no attempts had been made to find out why patients did not attend for their appointments.
- The trust approved the integrated governance board sub-committee terms of reference in August 2015. We requested minutes of clinical governance meetings held in the last six months but we did not receive evidence of clinical governance meetings for Northwick Park Hospital.

Outpatients and diagnostic imaging

- We saw from the corporate risk register there were three high rated risks in the division covering outpatients and diagnostics including security and capacity for storage of records.
- A copy of the risk register dated 28 August 2015 had six risks related to outpatients including lack of call bells in patient toilets within the outpatient department.
- Information about risks, governance and monitoring for outpatient and diagnostic services were inconsistent and lacked coherence. For example, diagnostic services collecting and monitoring information inconsistently across the three hospital sites.
- Outpatients performance data is reported within the in-patient information for the divisions. There was a lack of trust oversight of governance data for diagnostic and outpatient departments and information provided lacked reliability.
- We were not assured governance of the outpatient and diagnostic service at Northwick Park Hospital was robust enough to ensure risks are captured, mitigated or that quality was monitored well to keep patients safe.
- Outpatient and diagnostic services had a risk register which identified some risks associated with the service. For example, poor patient experience due to overbooking clinics, lack of capacity in outpatients and lack of availability of medical records in time for clinics.
- There were gaps in monitoring information to improve the service. For example, we were told about a pilot text project to reduce the number of patients who did not attend (DNA). The trust told us there had not been an evaluation of the pilot.

Leadership of service

- The merger last year provided an opportunity to assess the skill mix and structures for managing outpatient services including medical records and booking services. The trust had recently identified more work was required to streamline processes and had begun to identify key roles and responsibilities.
- We found the lead roles and accountability of the present leadership structure lacked clarity because lines of accountability for outpatients and diagnostic services were split between four divisions.
- We spoke with a recently appointed manager responsible for progressing work required unifying patient records and trust outpatient appointment booking systems across the three sites. He told us he reports to the information management and technology (IM&T) director .
- The outpatients general manager and the radiology manager told us they reported to the divisional general manager for the integrated services division
- The clinics which are not part of the outpatients department for example neurology, cardiology, dermatology, respiratory and haematology report to the divisional director for medicine. Vascular, breast care and urology departments report to the divisional director for surgery.
- Staff within radiology told us their managers were supportive up to board level.
- We were told the senior management for radiology were supportive of evidence based business cases and this had resulted in purchase of new MRI equipment.
- Some outpatients managers for example in phlebotomy told us recent management changes had improved the support available to them.
- Staff we spoke to in oncology told us their managers were approachable and supportive.

Culture within the service

- All of the staff to whom we spoke were enthusiastic about the trust and predecessor organisations. For example 12 members of staff we spoke with had worked for the trust for between five and 29 years and were very proud of this. They told us they wanted to do a good job for their patients and were happy working for the trust.
- The trust scored above average for "percentage of staff feeling satisfied with the quality of work and the carethey are able to deliver" at 88% versus and average of 77% in the NHS staff survey 2014. This placed the trust in the top 20% of trusts for this question.
- We found the culture within the hospital outpatient departments was focussed on maintaining the status quo. Staff we spoke with were proud of the patient care they provided but were not able to describe any innovations they had undertaken or work which had brought about improvements.
- We asked four of the staff a direct question within the medical records and booking services ‘what they would like to be improved or changed’. They did not identify any sustainable measures. Suggesting for example, that other services administrative function be co-located with medical records.

Outpatients and diagnostic imaging

- Diagnostic and imaging services staff were pro-active in improving services through, "growing their own talent" through additional training opportunities for staff to become more skilled and or qualified. For example training band 5 radiographers to band 6 standard and promoting them.
- However, the trust scored within the lowest 20% for questions in relation to discrimination (20% versus average of 11%) and equal opportunities for promotion at work (78% versus average of 87%).

Public engagement

- Six patients told us during the course of the inspection that outpatient appointments were often difficult to obtain and lacked supporting information about what to expect; the waiting times were long and car parking was insufficient.
- We observed a trust feedback box on the wall in outpatient area three. We asked staff in outpatient area three if there were any forms for patients to comment and were told "No". Staff we spoke with did not know if there ever had been any feedback forms or what would happen to the information if there was.
- The trust uses social media to communicate from the trust website. None of the staff we spoke with made reference to this form of communication with patients.

Staff engagement

- Diagnostic staff proudly told us they had been given a trust award for their cross-site working following the merger.
- The trust scored well in some of the NHS staff survey 2014 indicators, for example in the 'Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver' 88% versus an average of 77% and 'staff motivation at work' 4.02 versus 3.86 points. The 'Percentage of staff agreeing feedback from patients/service users is used to make informed decisions in their directorate/department' scored 62% versus a national average of 56%. These scores placed the trust in the top 20% of trusts for these aspects of staff engagement.
- However, the trust also scored in the bottom 20% for 'percentage of staff experiencing violence at work' 5% versus national average of 3%; 'Percentage of staff believing the trust provides equal opportunities for career progression or promotion' 78% versus 87%; 'Percentage of staff experiencing discrimination at work in last 12 months' 20% versus 11% nationally.

Innovation, improvement and sustainability

- We were told by managers attempts to remind patients by text about their appointments and extra clinics to reduce backlogs had been discontinued owing to financial constraints.
- A senior diagnostics manager told us about value improvement work they had carried out with support from McKinsey. This was a complex project requiring multidisciplinary support for changing job plans, rotas and working times to improve the MRI service to in-patients.
- Booking staff and service managers told us about attempts underway to reduce waiting times for patients including consultant review of diagnostic tests in urology and surgery and discharging patients with normal range test results who did not need to be seen for a follow up appointment. They used a patient tracking list which was checked daily and reminders were sent by the trust 18-week referral to treatment lead for patients who had waited almost 18 weeks without having an appointment.
- We were told about planned improvements which included moving to an electronic document management system.
- We did not identify any on-going or planned innovation work within outpatients.
- We found limited evidence of completed outpatients reviews or practice innovation. For example we were told by the outpatients charge nurse about plans to improve the phlebotomy service for patients receiving anti-coagulation medication. We requested a copy of the business plan for this change, but did not receive any evidence to support the statement made by the outpatients charge nurse.
- Three managers told us of plans to integrate healthcare records and create an anti-coagulation clinic. We saw the trust had a time bound plan for the records project. We did not see evidence the implementation of an anticoagulation clinic had the backing of the trust board.

Outstanding practice and areas for improvement

Outstanding practice

- We saw several areas of good practice or progress including:
- a newly opened emergency department at Northwick Park
- a refurbished and child friendly ward for children's care called Jack's Place.
- caring attitudes, dedication and good multi-disciplinary teamwork of clinical staff.
- good partnership working between urgent and emergency care staff and London Ambulance staff.
- good induction training for junior doctors.
- research projects into falls bundles, stroke trials and good cross site working in research.
- Staff told us there were good opportunities for training and career development.
- We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner.
- The play specialists in services for children demonstrated how they could make a difference to the service and its environment in meeting the needs of the children and young people. This includedan outstanding diversional therapy approach for children and young people, which was led by the play specialist and school tutor.

Areas for improvement

Action the hospital MUST take to improve

- Improve consultant cover on eHDU to include out of hours and weekend working
- Provide consultant radiologist support at weekends to ensure accuracy of clinical diagnosis.
- Ensure all medical and nursing staff are reporting all reportable incidents on Datix.
- Improve access to services and patients flow through the ED at Northwick Park to wards on the hospital.
- Set in place a recovery plan to improve performance and consistently meet national 4 hour waiting targets in ED.
- Set an action plan to address poor performance against College of Emergency Medicine audit measures on pain relief, renal colic, fractured neck of femur and consultant sign off.
- Improve mandatory training levels and support for all staff to reach trust targets of 95%.
- Ensure staff receive training and have their knowledge assessed in Mental Capacity and Deprivation of Liberty safeguards.
- Review infection prevention and control (IPC) practice and ensure correct IPC dress protocols are observed for all staff.
- Improve hand hygiene to show audits resulting in above 90% compliance and leading to 100%.
- Monitor required checks and cleaning of equipment including epidural trolleys.
- Improve the environment of the stroke wards at Northwich Park Hospital.
- Ensure improvements in handovers between ED and the wards at Northwick Park with clarity including MRSA screening and medicines management.
- Ensure patients' nutrition and hydration is monitored with fully completed records on medical wards including Malnutrition and Universal Scoring Tools (MUST).
- Improve record keeping with respect to fluid balance charts.
- Review drug round timings to minimise medicines errors.
- Review therapy visits on wards to prevent and minimise patients missing therapy.
- Ensure improvement in data completeness for patients having major bowel cancer surgery in line with the England average of 87% and up from the hospital performance of 30%.
- Review and improve the post-operative environment in which children recover following surgery.
- Review service level agreements related to the provision of surgical instruments.

Outstanding practice and areas for improvement

- Provide sufficient trained and experienced medical and nursing cover on eHDU at all times including out of hours and at weekends to ensure immediate availability on the unit.
- Set up a formal escalation process for deteriorating patients on eHDU.
- Ensure all eHDU handovers are consultant led.
- Ensure medical care on eHDU follows Faculty of Intensive Care Medicine guidelines.
- In maternity and gynaecology address safety concerns in relation to midwife shortages, lack of safety thermometers displayed and pressures on single staff covering more than one area, for example triage and observations simultaneously.
- Review the maternity risk register to include missing issues such as lack of soundproofing in the bereavement room.
- Implement a hospital wide training programme to ensure ward staff understanding of end of life care and the Last Days of Life Care Agreement (LDLCA).
- Improve signage for patients in outpatient clinics.
- Address items on the OPD risk register including lack of capacity, lack of complete medical records, and overbooking of clinics.
- Ensure incidents in OPD are reported, escalated, investigated with learning derived and shared.
- Review and improve consultant cover in haematology .
- Improve facilities in the haematology day care clinic.
- Ensure adequate emergency evacuation procedures in outpatients and diagnostic imaging (OPD)
- Ensure that blood testing results for patients on anti-coagulant medications are made known to patients and their GP's without delay and to protect them from the risk associated with known medication side effects.

Action the hospital SHOULD take to improve

- Risks associated with patient treatment environments are appropriately identified, assessed and mitigated to ensure patients are protected from the risks associated with unsafe environments.
- Must ensure that blood testing results for patients on anti-coagulant medications are made known to patients and their GP's without delay and to protect them from the risk associated with known medication side effects.
- The trust must ensure that training and awareness of emergency evacuation procedures for outpatient services are accurately documented and staff are trained in their use so that patients are protected from the risks associated with major incidents.
- The trust must ensure that adequate procedures to ensure destruction of unused controlled drugs are made according to the Misuse of Drugs Regulations 2001.
- The trust must improve the culture of incident reporting by staff to ensure that incidents are identified and lessons can be learned as well as staff provided with feedback and informed of learning from incidents.
- The hospital must ensure medical care on the eHDU follows Faculty of Intensive Care medicine guidelines.
- The hospital must ensure appropriate radiology support out of hours.
- The hospital must improve monitoring of nutrition and hydration through complete and reviewed assessments such as malnutrition and universal scoring tools.
- Identify and act on all risks which may affect patient safety and service provision.
- Ensure staff receive training and have their knowledge assessed with regard to Mental Capacity and Deprivation of Liberty Safeguards.
- Ensure catering staff have regular infection control training and adhere to required practices.
- Review the post-operative environment in which children were recovered following surgery.
- Monitor required checks and cleaning of epidural trolleys.
- Review service level specifics related to the provision of surgical instrumentation.
- Improve referral to treatment times in surgical specialties.
- Improve theatre utilisation and efficiencies related to start and finish times.
- Ensure final checks of swab counts and instruments are undertaken with verbal confirmation before the surgeon de-scrubs.
- Review effectiveness of the pre-surgery team brief.
- Develop appropriate surgical care pathways.
- Review compliance with the admissions criterion for patients accepted into the surgical assessment unit.
- Review the surgical environment with respect to the needs of individuals living with dementia.

Outstanding practice and areas for improvement

- Improve accessibility of medical records for patients attending pre-assessment.
- Correct the misfiling of patient information and improve checking processes.
- Ensure COSHH assessments and arrangements are up to date and maintained.
- Develop care plans which enable individualised information to be reflected and acted upon by staff.
- Review and act on patient outcomes resulting from national audit findings.
- Develop and communicate the vision and strategic aims of the surgical directorate to all staff.
- Improve engagement and visibility of trust board members.
- Increase public engagement with respect to surgical services.
- Ensure staff treat patients with respect and dignity at all times.
- Ensure that patients receive an outpatient appointment within the defined target time of two-weeks for suspected malignant disease and within 18 weeks for routine treatment.
- Identify the reasons underlying the high did not attend rates (DNA) and take action to minimise non-attendance.
- Improve flow through the hospital so patients are admitted, transferred and discharged in a timely manner from A&E and inpatient medical wards.
- Improve nurse staffing levels so there are less vacancies, less reliance of agency staff, and less effect on acuity and dependency when new units open.
- Improve mandatory training rates.
- Review the inpatient medical ward environments so that they do not pose a risk to patients, particularly those that are immune compromised.
- Ensure cross site working at department level so there is monitoring of performance and support arrangements across different staff groups.
- Mandatory end of life care training for allstaff across the trust to promote equity of knowledge, not only in syringe drivers and symptom control, but also in the understanding of end of life care.

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

Action we have told the provider to take

The table below shows why there is a need for significant improvements in the quality of healthcare. The provider must send CQC a report that says what action they are going to take to make the significant improvements.

Why there is a need for significant improvements	Where these improvements need to happen
This notice is served under Section 29A of the Health and Social Care Act 2008. **This warning notice serves to notify you that the Care Quality Commission has formed the view that the quality of health care provided byLondon North West Healthcare NHS Trust for the regulated activities above requires significant improvement.** The Commission has formed its view on the basis of its findings in respect of the healthcare being delivered in accordance with the above Regulated Activities at the location identified below: Northwick Park Hospital Watford Road Harrow Middlesex HA1 3UJ **The reasons for the Commission's view that the quality of health care you provide requires significant improvement are as follows:** • You do not have the appropriate medical staffing or competency of staff of the Elective High Dependency Unit (eHDU). • You are not reporting adverse incidents in your surgical services. • You do not have appropriate staffing competency out of hours in radiology. **Significant improvements are required in relation to the quality of the health care provided by the trust in relation to the regulated activities set out in this Notice, by way of having effective systems in place that address the points numbered 1 to 3 above.** • You do not have the appropriate medical staffing or competency of staff of the Elective High Dependency Unit (eHDU). • The eHDU was set up as a postoperative care unit which would not be subject to the same requirements	Significant improvements are required in relation to the quality of the health care provided by the trust in the regulated activities set out in this Notice, by way of the Trust ensuring that care and treatment is provided in a safe way for critical care service users, through the provision of such services by sufficient numbers of appropriately qualified, competent, skilled and experienced staff. **You are required to make the significant improvements identified above regarding the quality of healthcare by 7 January 2015.**

as a critical care unit. However information obtained during our inspection and provided by the hospital in November 2015 such as the Elective High Dependency Unit Operational Policy indicates surgical patients can be admitted as a 'step-down' from the Intensive Therapy Unit or from any other unit in the hospital providing the patient has a surgical pathway, even if the patient has not been to theatre. This information demonstrates the eHDU is used as a high dependency unit rather than as a post-operative care unit and so is subject to the relevant critical care requirements.

- Information provided by the hospital in November 2015 indicates none of the consultants currently or since the eHDU opened responsible for patients within eHDU have Faculty of Intensive Care Medicine accreditation. This is not compliant with recommendations from the Faculty of Intensive Care Medicine Core Standards which state "care must be led by a consultant in intensive care medicine" and is not appropriate medical staffing as it places patients at risk of receiving suboptimal medical care and treatment.
- Out of hours medical cover is provided by the on-call anaesthetic registrar who is also responsible for emergency theatre cases, with telephone support from the on-call anaesthetic consultant. Information provided by staff during our inspection detailed the busy workload of the on-call registrar which meant the eHDU frequently had no doctor present on the unit. This is not compliant with recommendations from the Faculty of Intensive Care Medicine Core Standards which state "There must be immediate access to a practitioner who is skilled with advanced airway techniques" and is not appropriate for the patient cohort cared for on the unit. Patients are at risk of harm due to lack of immediate medical cover available in the event of sudden deterioration.
- You are not reporting adverse incidents in your surgical services.
- During our inspection visit to the theatre department at Northwick Park Hospital on 20 October 2015 we were made aware of two patient-related incidents which had occurred that day. The first was of a patient

not receiving the required pre-operative preparation. The second was of another patient whose consent had not been completed fully to take into account the need for two surgical procedures.

- At the request of consultant surgeons, we met on 22 October 2015 with six consultants and two other doctors. We were informed by the consultants in this discussion that formal reports for adverse events were not always completed. They said the reasons for this was they found the forms were too laborious and because of the failure to action matters reported previously.
- During our formal discussions with the surgical directorate leads on Friday 23 October 2015 we requested a report from the Datix system of incidents reported on or after 20 October 2015 inclusive of 23 October 2015. The information was provided later on the same day of 23 October 2015, and we found neither of the two incidents which occurred on 20 October 2015 had been reported on the Datix system.
- We reviewed a serious incident report, dated 28 July 2015, which pertained to an incident that occurred on 9 April 2015 ref (2015 25470).The incident related to the mixing up of two female patients investigative pathology. This had resulted in one of these individuals having an unnecessary and radical appearance altering operation at another hospital. This serious incident which the trust informed us they had sought and received advice that it did not meet the criteria for a never event, was nevertheless preventable. Had preventative measures been implemented, it would not have occurred.
- Minutes of the Joint Surgical and Anaesthetic Morbidity and Mortality Meeting held on 29 September 2015 contained evidence indicative that incidents had not always been reported. Minutes stated that all radiology addendum reports that had an effect on a patient's outcome needed to be Datixed and highlighted in order to be logged as evidence. We noted that two patients with delayed diagnosis due to misdiagnosis on initial CT should have been included as evidence for discussion with radiology regarding addendums.
- You do not have appropriate staffing competency out of hours in radiology.
- In our discussion with the aforementioned medical staff on 22 October 2015, they reported lack of

This section is primarily information for the provider

Enforcement actions (s.29A Warning notice)

consultant radiology cover at weekends. They informed us this had contributed to patients missed pathologies. This has resulted that, in place of consultant staff without requisite experience and skills have continued to review patient scans.