

Royal Brompton and Harefield NHS Foundation Trust

Harefield Hospital

Quality Report

Hill End Road

Harefield

UB9 6JH

Tel: 01895 823737

Website: <http://www.rbht.nhs.uk/about/our-work/harefield/>

Date of inspection visit: 14 - 16 June 2016

Date of publication: 10/01/2017

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

Good



Medical care

Good



Surgery

Good



Critical care

Good



End of life care

Good



Outpatients and diagnostic imaging

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

The Royal Brompton and Harefield NHS Foundation Trust is the only specialist heart and lung unit in the country that treats both children and adults. The trust is home to Europe's largest centre for the treatment and management of cystic fibrosis.

The organisation provides 512 inpatient beds, of which 360 are general acute beds, 59 paediatric beds and 93 critical care beds. They deliver in the region of 38,619 inpatient admissions and 178,495 outpatient attendances (2014/15).

The organisation delivers care across two hospital sites: the Royal Brompton Hospital site in Chelsea and the Harefield Hospital site to the north of London. They employ in the region of 3,298 staff and have a financial revenue of £367.5 million, generating a financial deficit of £3.3 million during 2015/16.

The organisation has a stable executive and non-executive leadership team, led by Chair Neil Lerner and Robert Bell, CEO of eleven years. Two members of the Executive team took up post within 12 months prior to inspection, including the Director of Nursing and the Interim Medical Director.

The trust's vision and mission is to be the UK's leading specialist centre for heart and lung disease, developing services through research and clinical practice to improve the health of people across the world.

We inspected The Royal Brompton and Harefield NHS Foundation Trust, including the six core services: Medicine, Surgery, Critical Care, Services for Children and Young People (the Royal Brompton site only), Outpatients and Diagnostic services and End of Life Care services. We inspected the two acute sites - the Royal Brompton Hospital and the Harefield Hospital.

Harefield Hospital is situated in the countryside to the north of London.

The hospital has more than 1,300 staff, five operating theatres and four catheter laboratories. Harefield Hospital has 168 beds, including beds for:

- Cardiac and thoracic surgery
- Cardiology
- Day case unit
- Adult intensive care
- Transplant surgery

The hospital is one of the largest centres in the world for heart and lung transplants. It has jointly pioneered work in the development of 'artificial hearts' (also known as left ventricular assist devices or LVADs).

The hospital has a dedicated heart attack centre which deals with heart attack emergencies from outer north-west London, providing primary angioplasty in the specialist catheter laboratories.

Our key findings were as follows:

We rated Harefield Hospital as good overall because:

- There was a positive culture of incident reporting and there were established processes for investigating incidents. 'Grand Rounds' took place every week and learning from incidents was one of the topics often talked about. We saw that incidents and mortality was reviewed at the monthly Harefield Quality and Safety Group meetings for the heart division and that action points were identified. Incident management was in line with the duty of candour.

Summary of findings

- There was an open and transparent culture across the hospital, where staff felt comfortable to express their views and approach managers with their concerns. Learning from incidents and complaints was shared across the specialist team and the trust, now that data had been coded in such a way to allow this.
- Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance and staff worked together in a multidisciplinary environment to meet patients' needs.
- We observed good infection prevention and control (IPC) practices by staff and noted compliance audits completed in this area. Clinical equipment was serviced, clean and functioning. Daily monitoring of resuscitation equipment had taken place in most surgical areas.
- Consent processes were robust and documentation associated with these processes was adapted to the individual patient's needs and understanding.
- Patients and their families were continually positive about the care and treatment they received at the Harefield Hospital. They told us they felt involved in their care and built strong, caring and supportive relationships with staff.
- Feedback from patients and their relatives was complimentary about the care they received on the wards; they told us staff were kind and tried to make them feel comfortable. Patients told us staff came quickly when they used the call bell.
- Staff had a good understanding of safeguarding principles and knew what to do to keep people safe. Staff had access to specialist support if they needed help with safeguarding or child protection.
- Although the wards had vacancy rates of 18.5% whole time equivalents, we observed staffing levels were in line with planned staffing levels. Staffing levels were tracked throughout the day and nursing staff would be moved across the division as needed.
- Multidisciplinary working underpinned the care provided to patients. Consultant-led multidisciplinary board rounds were held on a daily basis.
- A pain scoring system was used with patients across the wards. Staff had access to the pain management team which was led by a consultant anaesthetist and was available for patients for both chronic and acute pain.
- Nursing staff had access to practice educators and ward-based mentors. New staff were supernumerary on the wards for the first three weeks and received clinical supervision. Nurses told us there were opportunities for learning and development and they could access training online. The practice educators held study days to assist nursing staff with their Nursing & Midwifery Council (NMC) revalidation.
- Staff had access to allied health professionals such as speech and language therapists, dietitians, tissue viability specialists, physiotherapists and clinical nurse specialists.
- Patients admitted over the age of 75 years were screened for dementia within 72 hours of admission.
- The service was led by experienced clinicians with autonomy in decision making and a clear strategy for the service in place.
- There were suitable governance arrangements in place. Clinical directors felt they were supported and described being supported top down and bottom up in shaping their services.
- There was evidence of engagement with the public and staff members. Staff were encouraged to develop ideas which could improve the quality and/or efficiency of the trust's services.
- The trust was consistently above the England average for the 31 day cancer waiting times from April 2015 to April 2016.
- Diagnostic waiting times were consistently below the England average from January 2015 to January 2016.
- The 'did not attend' (DNA) rate was below the England average from September 2014 to August 2015.

However:

- Compliance with mandatory training was below the trust's target of 75% for medical staff and allied health professionals.
- There was no on site pharmacy service available from 1pm on Saturdays and all day Sunday, this was covered by an on call service.

Summary of findings

- Systems were in place to ensure incidents were reported, investigated and lessons learnt. However, follow up of incidents within the trusts 10-day period was poor.
- Senior medical staff did not fully complete the World Health Organisation (WHO) checklist despite several discussions about the risk to patient safety. The WHO checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of surgical procedures.
- The referral to treatment (RTT) national indicator trust performance fell below both the England average and referral to treatment standard of 92%. The 18-week RTT times for elective cardiac surgery were an issue due to an increased demand in the service. The trust explained they aimed to be back to standard by 2017.
- The performance for the 62 day cancer waiting time was consistently worse than the England average from April 2015 to April 2016.
- Staff and patients told us some clinics regularly started late and led to longer waits for patients.
- Cancellation rates of elective patients trust-wide had a marked increase in the first three quarters of 2015 to 2016 and this did not show signs of improvement. Many patients were rebooked for treatment within 28 days of cancellation.

We saw several areas of outstanding practice including:

Outpatients and Diagnostic Imaging

- Diagnostic and imaging services provided a number of examples of outstanding practice, including the imaging department's expertise in a range of inflammatory respiratory diseases including amongst others asthma, allergy, COPD, cystic fibrosis, idiopathic pulmonary fibrosis, and acute lung injury.
- The imaging department's research included exhaled inflammatory biomarkers, skeletal muscle biopsies, imaging, extensive lung physiology techniques, nasal and bronchoscopic sampling,, bronchial challenges, as well as a large range of preclinical techniques including models of asthma and COPD.

Surgery

- The Harefield transplant team pioneered the Organ Care System in cardiothoracic transplantation. This is a method for transporting and optimising potential donor hearts. Most other cardiothoracic transplant services have adopted this system. A lung transplant version has also been utilised.
- VAD (ventricular assist device) team members were some of the most highly skilled in the UK. They could care for patients undergoing surgery for the insertion of an artificial heart without the need for the company who make the heart being present. No other service in the UK can provide this without the company being present.
- Patients undergoing surgery at the Harefield Hospital had excellent outcomes for cardiac, thoracic and cardiothoracic transplant (heart, lung and heart-lung transplant).

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

The trust should:

End of Life Care

- Ensure ward nurses should undergo regular syringe driver update training to maintain their competence.
- Audit the use of opioids within palliative care as per NICE Quality Standard CG140.
- Provide formal training to staff so that they feel confident in recognising patients in the last stages of life and they are able to provide the care that they require.
- Ensure nursing staff within the specialist team are up to date with their mandatory training.
- Ensure PALs officers are given full role specific training rather than relying on previous work experience.
- Provide consultant cover seven days a week, face to face for palliative care patients as per national professional guidance.
- Use a valid assessment tool to document patients' care at the end of their life to ensure compliance and consistency.
- Improve their data collection process so that relevant data is easily accessible to improve patient care.

Summary of findings

- Flag patients with learning difficulties or dementia within their electronic records systems so that staff are immediately aware of a patient's extra needs.
- Record the number of people that died at their preferred place of death for audit and improvement purposes.
- Record end of life care complaints separately to enable learning and changes to take place.
- Meet all national KPIs as set out in the national audit for end of life care so that it can compare and improve itself and encourage development and change.

Outpatients and Diagnostic Imaging

- Ensure all clinics start at their published time, and consultants do not accept work commitments inside the hours specified in their job plans.
- Reduce the time patients spend waiting in the outpatients waiting room.

Critical Care

- Follow up on concerns around inconsistencies in patient observation scoring including the visual infusion phlebitis (VIP) score and scores relating to confusion and delirium.
- Ensure that staff are appropriately and consistently managing risks associated with venous thromboembolism (VTE) in all critical care wards.
- Ensure there is consultant intensivist cover in all critical care wards including HDU at weekends in line with the Faculty of Intensive Care Medicine (FICM) guidance on medical staffing.

Surgery

- Ensure staff complete the WHO checklist in its entirety and that staff are present for the 'five steps to safer surgery' process.
- Ensure surgical staff are completing patients observational NEWS charts fully and escalating unwell patients as a matter of urgency.
- Follow up on concerns around the culture in relationships between senior surgical staff and their colleagues.
- Ensure staff are trained in understanding the sepsis six pathway and responding to septic patients.
- Ensure that it is meeting the national indicator for cardiac surgery referral to treatment time.

Medicine

- Ensure that hand gel is clearly indicated at the entrance to the wards/clinical areas.
- Ensure that hand hygiene in the cath labs meets the trust's target of 90% for medical staff and allied health professionals.
- Ensure that mandatory training meets the trust's target of 75% for medical staff and allied health professionals.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service

Medical care

Rating

Good



Why have we given this rating?

- There was a positive culture of incident reporting and there were established processes for investigating incidents. 'Grand Rounds' took place every week and learning from incidents was one of the topics often talked about. We saw that incidents and mortality was reviewed at the monthly Harefield Quality and Safety Group meetings for heart division and that action points were identified.
- All the wards we visited were visibly clean. Wards had daily cleaning schedules in place, we saw the daily cleaning schedules were up to date and signed. Weekly checks were carried out by a cleaning supervisor.
- The introduction of the electronic prescription system had reduced the number of medication related incidents and promoted the safe prescription and administration of medication.
- Medication was stored securely and controlled drugs were locked in cupboards and checks were always completed to ensure there was enough in stock.
- The hospital used a national early warning score (NEWS) system to identify patients whose condition was at risk of deteriorating. The use of NEWS was audited across the trust between January and March 2015. Recommendations and action plans were put in place following the audit to address areas highlighted in the audit which included dissemination to senior nurses, raising staff awareness and training.
- Although the wards had a vacancy rate of 18.5% whole time equivalents (WTE), we observed staffing levels were in line with planned staffing levels. Staffing levels were tracked throughout the day and nursing staff would be moved across the division as needed.
- Multidisciplinary working underpinned the care provided to patients. Consultant-led multidisciplinary

Summary of findings

board rounds were held on a daily basis Monday to Friday on Oak and Acorn wards and attended by clinical nurse specialist, nurse in charge and the registrar on call consultant.

- Care was provided in line with NICE guidelines. New NICE guidelines were presented to the standards committee and NICE quality standards were reviewed.
- The audit programme was formalised and there was a programme of current audits being undertaken. The Heart division contributed to clinical audits e.g. medication used for secondary prevention after percutaneous coronary intervention (PCI). This data came from the MINAP database which can be tailored to provide local information.
- A pain scoring system was used with patients across the wards. Staff had access to the pain management team which was led by a consultant anaesthetist and was available for patients for both chronic and acute pain.
- Patients' nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition.
- Nursing staff had access to practice educators and ward based mentors. New staff were supernumerary on the wards for the first three weeks and received clinical supervision. Nurses told us there were opportunities for learning and development and they could access training online. The practice educators held study days to assist nursing staff with their Nursing & Midwifery Council (NMC) revalidation.
- Staff had access to allied health professionals such as speech and language therapists, dietitians, tissue viability specialist, physiotherapists and clinical nurse specialists.
- There were many thank you cards on display in Oak and Acorn wards demonstrating the gratitude of previous patients and their relatives and results from the NHS Friends and Family Test showed people would recommend the medical services provided by the hospital.

Summary of findings

- Patient confidentiality was maintained by staff during handovers, multidisciplinary meetings and ward rounds. Nursing staff were allocated to specific bay and signs were in place to ensure patients were aware which nurse was caring for them. Patients told us their privacy and dignity was preserved at all times and care we saw supported this.
- All feedback from patients and their relatives was complimentary about the care they received on the medical wards; they told us staff were kind and tried to make them feel comfortable. Patients told us staff came quickly when they used the call bell.
- Patients were offered pre assessment clinics by telephone as the hospital provided services to patients from the local area and nationally.
- The hospital's transport services provided services to patients across the UK and also picked patients up from Gatwick airport.
- During the period February 2015 to January 2016, 80% (10,728) of patients experienced no ward move.
- Patients admitted over the age of 75 years were screened for dementia within 72 hours of admission for dementia.
- There was a complaints policy in place and staff knew how to access it. Staff understood how to manage complaints locally and who to refer to for resolution or escalation. Contact details for the Patient Advocate and Liaison Service (PALS) were visible across the hospital.
- The service was led by experienced clinicians with autonomy in decision making and a clear strategy for the service was in place.
- There were suitable governance arrangements in place. Clinical directors felt they were supported and described being supported top down and bottom up in shaping their services.
- There was evidence of engagement with the public and staff members. Staff were encouraged to develop ideas which could improve the quality and/or efficiency of the trust's services.

Summary of findings

- There was a positive culture across the Heart division, managers were supportive and approachable. Staff also had opportunities for personal development and felt respected and valued.

However:

- Hand gel was not clearly indicated which meant that staff or visitors may find it hard to find at the entrance to the wards/clinical areas. A hand hygiene audit undertaken in the cath lab for the period July 2015 to March indicated that medical staff and allied health professionals scored below the trust target of 90%.
- Compliance with mandatory training was below the trust's target of 75% for medical staff and allied health professionals.
- There was no on site pharmacy service available from 1pm on Saturdays and all day Sunday, this was covered by an on call service.
- During the period April 2015 to March 2016 the trust was below the England standard of 92% for referral to treatment (RTT) for cardiology (88%).
- During the period September 2014 to August 2015 the average length of stay for elective patients in cardiology at Harefield Hospital was higher (3 days) than the England average (1.9 days).

Surgery

Good



- We observed good infection prevention and control (IPC) practices by staff and noted compliance audits completed in this area. Clinical equipment was serviced, clean and functioning. Daily monitoring of resuscitation equipment had taken place in most surgical areas.
 - The training information provided by the trust showed 100% staff attendance at mandatory training. Nursing staff did not know about the sepsis six even though this was an area the trust were trying to improve. Sepsis six is the name given to a bundle of medical therapies designed to reduce the death rates of patients with infection. Medical trainees had opportunities to attend simulation training however consultant led training was variable across the service.
-

Summary of findings

- Patients received evidenced based care and treatment and patients experienced excellent outcomes. There was participation in both local and national audits and other monitoring activities such a yearly peer review.
- Consent processes were robust and documentation associated with these processes was adapted to the individual patient's needs and understanding.
- Staff provided caring, compassionate and respectful care. They were positive about working in the service. Medical staffing levels and skill mix were adequate for the service. Nurse staffing levels were as planned or above planned levels across the service and there was ongoing recruitment.
- Patients and their families were continually positive about the care and treatment they received at the Harefield Hospital. They told us they felt involved in their care and built strong, caring and supportive relationships with staff.
- There was a strong emphasis on multidisciplinary team (MDT) working. There were MDT meetings four times a week on the transplant unit and regular meetings in the other surgical areas ensuring patients had a holistic care plan in place. Good MDT working existed between the trust and local hospitals with agreements for service provision as necessary including vascular surgery and dermatology.
- Service planning and delivery considered patients' needs, which meant changes to the service and its delivery benefited the patient. Support was in place for those patients and their families who had a learning disability or were living with dementia.
- The surgical directorate had a clear leadership structure in place. Although we saw areas of good practice it was highlighted that senior management had no clear plan of how to improve on poor areas of care noted on the trust wide risk register. This included compliance with the WHO five steps to safer surgery checklist and managing deteriorating patients with a national early warning score observation system.
- There were many examples of staff and patient engagement in service improvement including patient involvement in decorating theatres. Some

Summary of findings

staff had concerns that senior medical staff would not always take into account their ideas even if it meant service improvement. Staff and patients alike were proud to be a part of Harefield Hospital.

However

- Systems were in place to ensure incidents were reported, investigated and lessons learnt. However, follow up of incidents within the trust's 10-day period was poor. Incident management was in line with the duty of candour.
- Staff provided care in line with NICE guideline CG50 that guides assessment of patient risk. The service had protocols and guidelines in place to assess and monitor patient risk. However, staff did not always complete patient observations charts correctly, which may put patients at risk of deteriorating without staff escalating this to the medical team.
- Senior medical staff did not fully complete the World Health Organisation (WHO) checklist despite several discussions about the risk to patient safety. The WHO checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of surgical procedures.
- The referral to treatment (RTT) national indicator trust performance fell below both the England average and referral to treatment standard of 92%. The 18-week RTT times for elective cardiac surgery were an issue due to an increased demand in the service. The trust explained they aimed to be back to standard by 2017.
- Cancellation rates of elective patients trust-wide had a marked increase in the first three quarters of 2015 to 2016 and this did not show signs of improvement. Many patients were rebooked for treatment within 28 days of cancellation.
- Staff had concerns over the ability to manage the number of referred patients in the physical space they had within the wards. Senior members of staff were trying to find ways to expand the space they had by looking at currently unused parts of the hospital.

Summary of findings

Critical care

Good



- Patients were protected from avoidable harm. The working culture enabled staff to report incidents confidently and there was evidence of learning from incidents.
- Nurse and medical staffing consistently met the national best practice guidance of the Royal College of Nursing and the Faculty of Intensive Care Medicine.
- A team of practice facilitators and a practice educator worked in critical care to provide specialist training and learning to the clinical teams.
- Mandatory training mostly met the departmental target of 75%.
- Staff had a good understanding of safeguarding principles and knew what to do to keep people safe. Staff had access to specialist support if they needed help with safeguarding or child protection.
- Staff demonstrated good knowledge of the duty of candour and were able to explain when they would use this. Records we looked at showed us staff acted according to best practice.
- Care and treatment was delivered in line with national evidence based practice including from the Royal College of Nursing and the National Institute for Health and Care Excellence.
- Staff responded to and managed deteriorating patients in a way that managed risk and recorded observations regularly.
- A critical care outreach team provided a follow-up service for patients after they were discharged from ITU.
- There were clear governance structures in place and staff told us leaders were visible, supportive and approachable.
- Staff were clear on the strategy for critical care and knew what their role was in achieving this.

We also found some areas of outstanding practice:

- The work of the practice education team (four practice facilitators and a practice educator) where they provided teaching, learning support and supervision to staff.

Summary of findings

- Innovative practices by the critical care outreach team (CCOT), for example spearheading an acute kidney injury reduction strategy in thoracic surgical patients following a large number of acute kidney injury referrals.

However:

- Mandatory training for safeguarding fell below the departmental target of 75% for safeguarding children level two in the high dependency unit (HDU). Mandatory training also fell below the 75% target for infection control (70%) and for equality and diversity(70%) in ITU.

End of life care

Good



- There was an open and transparent culture across the trust, where staff felt comfortable to express their views and approach managers with their concerns. Learning from incidents and complaints were shared across the specialist team and the trust, now that data had been coded in such a way to allow this.
- The environment and equipment in both the hospital wards and the mortuary was suitable for purpose. Infection prevention control (IPC) measures were followed by staff from the mortuary, porters, specialist teams and while we observed care on the wards.
- Patient care records were completed with evidence that patients' needs were appropriately assessed and monitored. Staff clearly documented do not attempt cardio pulmonary resuscitation (DNACPR) decisions and ceilings of care. They considered different treatment options and showed clear involvement of patients and relatives in treatment decisions. Pain relief, symptom control and nutrition and hydration were well managed and individualised to each patient. The service recognised individuals with complex needs and tailored their care accordingly.
- There were enough specialist nurses on the palliative care team to enable them to see all patients on their caseload. Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as and when required.
- The specialist team had introduced end of life care (EOLC) champions that were based on all wards to

Summary of findings

assist, train and support ward staff with the care of patients at the end of life. Resource folders were accessible on all wards for staff to refer when they needed guidance or information on issues relating specifically to EOLC.

- A multidisciplinary team approach was evident both across the specialist team and across the hospital. Patients at the end of life were cared for compassionately and holistically, with input from psychology, chaplaincy, physiotherapists and other allied health professionals (AHPs) as necessary. The needs of relatives were also considered and addressed by the wards, specialist team and dedicated bereavement service.
- A recently developed EOLC strategy aimed to ensure that the specialist team were able to support other staff even further in the event of death. A detailed educational strategy was in place and due to be rolled out to ensure staff across the trust felt confident with caring for patients at the end of life. Regular meetings and forums took place that addressed issues in EOLC with various stakeholders. This included a specific EOLC steering group that met quarterly to discuss any issues specific to EOLC.

However:

- There was a lack of consultant presence at Harefield Hospital. There was currently only a 0.2 whole time equivalent (WTE) consultant, who was employed through a service level agreement with East and North Hertfordshire NHS Trust. The service had submitted a business case to the trust board for increased consultant cover but this was not yet in place.
- The trust had not introduced a validated assessment tool to document care of patients at the end of life when the Liverpool Care Pathway was discontinued in 2013. This meant a lack of consistency and knowledge across wards regarding care of patients nearing end of life.
- Data collection for issues relating to EOLC was an issue, limiting the amount of audit activity that the specialist team could take part in and use to improve patient outcomes.

Summary of findings

- The specialist team's core working hours were 8.30am to 5pm, Monday to Friday. This was contrary to national recommendations, stating that specialist palliative care should be available face-to-face, seven days per week.

Outpatients and diagnostic imaging

Good



- Safety procedures and maintenance contracts were in place for specialist equipment. Radiation protection and medical physics support were available and policies and procedures could be accessed by all staff.
- All medicines were stored securely and medical records were available for all patients in outpatient clinics.
- Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance and staff worked together in a multi-disciplinary environment to meet patients' needs.
- Staff were competent to perform their roles and took part in benchmarking and accreditation schemes.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff and care was planned that took account of patients' needs and wishes.
- The trust was consistently above the England average for the 31 day cancer waiting times from April 2015 to April 2016.
- Diagnostic waiting times were consistently better than the England average from January 2015 to January 2016.
- The 'did not attend' DNA rate was better than the England average from September 2014 to August 2015.
- The percentage of diagnostic waiting times over six weeks was lower than the England average between October 2013 and January 2016. The only exception was July 2015.
- The level of complaints received regarding outpatient services was consistently low. Staff worked to address any concerns raised by patients at first point of contact.
- Arrangements were in place to accommodate people in vulnerable circumstances.

Summary of findings

- Managers and clinical leads were visible and approachable and had a good knowledge of performance in their areas of responsibility. There was an open and honest culture within the service, morale was good and there was evidence of continuous improvement and development of staff and services.
- Diagnostic and imaging services provided a number of examples of outstanding practice, including working with industry to develop new technologies.

However:

- The performance for the 62 day cancer waiting time was consistently worse than the England average from April 2015 to April 2016.
 - Staff and patients told us some clinics regularly started late and led to longer waits for patients.
 - Space across the hospital posed challenges for storing equipment.
-

Harefield Hospital

Detailed findings

Services we looked at

Medical care (including older people's care); Surgery; Critical care; End of life care; Outpatients and diagnostic imaging.

Detailed findings

Contents

Detailed findings from this inspection	Page
Background to Harefield Hospital	18
Our inspection team	19
How we carried out this inspection	19
Facts and data about Harefield Hospital	19
Our ratings for this hospital	21
Action we have told the provider to take	127

Background to Harefield Hospital

The Royal Brompton and Harefield NHS Foundation Trust is the only specialist heart and lung unit in the country that treats both children and adults. The trust is home to Europe's largest centre for the treatment and management of cystic fibrosis.

The organisation provides 512 inpatient beds, of which 360 are general acute beds, 59 paediatric beds and 93 critical care beds. They deliver in the region of 38,619 inpatient admissions and 178,495 outpatient attendances.

The organisation delivers care across two hospital sites: the Royal Brompton Hospital site in Chelsea and the Harefield Hospital site to the north of London. They employ in the region of 3,298 staff and have a financial revenue of £367.5 million, generating a financial deficit of £3.3 million during 2015/16.

The organisation has a stable executive and non-executive leadership team, led by Chair Neil Lerner and Robert Bell, CEO of eleven years. Two members of the Executive team, took up post within 12 months prior to inspection, including the Director of Nursing and the Interim Medical Director.

The trust's vision and mission is to be the UK's leading specialist centre for heart and lung disease, developing services through research and clinical practice to improve the health of people across the world.

The trust provides the following services:

- Cardiology

- Cardiothoracic surgery
- Cardio-respiratory critical care services for adults and children
- Children's & Adolescent services
- Lung cancer service
- Respiratory medicine

We inspected The Royal Brompton and Harefield NHS Foundation Trust, including the six core services: Medicine, Surgery, Critical Care, Services for children and Young People (the Royal Brompton site only), Outpatients and diagnostic services and End of Life Care services. We inspected the two acute sites at the Royal Brompton and Harefield campus.

Harefield Hospital is situated in the countryside to the north of London.

The hospital has more than 1,300 staff, five operating theatres and four catheter laboratories. Harefield Hospital has 168 beds, including beds for:

- Cardiac and thoracic surgery
- Cardiology
- Day case unit
- Adult intensive care
- Transplant surgery

Detailed findings

The hospital is one of the largest centres in the world for heart and lung transplants. It has jointly pioneered work in the development of 'artificial hearts' (also known as left ventricular assist devices or LVADs).

The hospital has a dedicated heart attack centre which deals with heart attack emergencies from outer north-west London, providing primary angioplasty in the specialist catheter laboratories.

Our inspection team

Our inspection team was led by :

Chair: Dr Nick Bishop, Non-Executive Director, Great Western Hospitals NHS Foundation Trust.

Team Leader: Nicola Wise, Head of Hospital Inspection Care Quality Commission.

The trust was visited by a team of CQC inspectors and assistant inspectors, analysts and a variety of specialists.

This was comprised of consultants in: cardiovascular, cardiothoracic surgery, critical care , paediatric respiratory medicine, paediatric critical care, palliative care, Cardiac Physiology and Radiology.

The team also comprised of nurses with backgrounds in cardiothoracic medicine, cardiothoracic theatres, paediatric critical care, paediatric respiratory care, general paediatric and palliative care. The team also consisted of cardiothoracic technicians, and specialist advisors with board-level experience, safeguarding specialists and two experts by experience.

How we carried out this inspection

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

Is it safe?

Is it effective?

Is it caring?

Is it responsive to people's needs?•

Is it well-led?

The inspection team inspected the following core services:

- Medicine
- Surgery
- Critical Care
- Outpatients and diagnostic imaging

- End of Life Care

Before our inspection, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These organisations included the clinical commissioning groups, NHS Improvement, Health Education England, General Medical Council, Royal College of Nursing, NHS Litigation Authority and the local Healthwatch.

As part of this inspection we observed how patients were being cared for, we spoke with patients, carers and/or family members and reviewed patients' personal care or treatment records. We held focus groups with a range of staff in the hospitals, including doctors, nurses, allied health professionals, administration, senior managers, and other staff. We also interviewed senior members of staff at the trust.

Facts and data about Harefield Hospital

The Royal Brompton and Harefield NHS Foundation Trust is the only specialist heart and lung unit in the country

Detailed findings

that treats both children and adults. The trust is home to Europe's largest centre for the treatment and management of cystic fibrosis. The adult congenital heart disease unit was the first of its kind in Europe.

As a tertiary service it also provides services to a much wider population, as well as for overseas patients.

Key figures

Beds: The trust houses a total of 512 beds; of which 360 are general and acute beds; 59 are allocated children's beds and 93 are classed as critical care beds.

Staff: At the time of inspection the trust employed 3298 whole time equivalent (WTE) staff, of which 491 are medical, 1376 are categorised as nursing and 1431 are categorised as 'Other.'

Financial: The trust had a revenue of £367,510,769, with a full Cost: £370,828,291. This resulted in a reported deficit of £3,317,522.

Activity (Acute): The trust reported 38,619 inpatient admissions and 178,495 outpatient attendances in 2014/15.

Deprivation: Out of 326 authorities, Hillingdon is ranked 200th most deprived authority in England. In the 2015 Indices of Multiple Deprivation Hillingdon is in the third quartile for deprivation.

Safe

One never event was reported from March 2015 to March 2016.

The trust had 25 serious incidents requiring reporting and investigating via the Strategic Executive Information System (STEIS). The majority of these related to pressure ulcers and surgical/invasive procedures.

The trust reported 16 incidents via the National Reporting and Learning System (NRLS) in the same period, which was better than the England average.

No cases of MRSA were reported for the period February 2015 to January 2016

There were no reported cases of Meticillin Resistant Staphylococcus Aureus (MRSA) for the period February 2015 to January 2016

The trust reported 22 cases of C.Diff for the period January 2015 to January 2016, but numbers remained below the England average from July 15 to January 2016.

Eight cases of MSSA were reported but with the exception of December 2015, numbers were below the England average

The proportion of registrars employed by the trust was higher than the England average. The proportion of middle career and junior doctors were lower than the England average and the proportion of consultants was in line with England averages.

Effective

The trust had one elevated risk for the Composite indicator: In-hospital mortality-Cardiological conditions and procedures.

Caring

- The trust was in the top 20% of trusts for eight of the 34 questions and in the bottom 20% for nine questions in the Cancer Patients Experience Survey.
- Performance was mostly in line with England averages in the Patient Led Assessment of the Care Environment 2015
- The trust performed better than the England for four of the 12 questions in the CQC Inpatient Survey 2014 and in line with other trusts for the remainder of questions
- Performance in the NHS Friends and Family Test was consistently better than the England average from March 2015 to March 2016.

Responsive

- Between April 2013 and August 2015 the majority of delayed transfers of care were due to completion of assessments (35.1%), and awaiting further NHS non-acute care. Both were higher than the England average of 18.5% and 20.2% respectively
- Bed occupancy has varied between quarter two 2013/14 to quarter three 2015/16 and was above the England average on three occasions before quarter three 2013/14 and then again in quarter four 14/15. Most recently it has been below the England average. (This data reflects overnight bed usage only).

Detailed findings

- The trust received 80 written complaints in 2014/15, an increase of 15 written complaints from 2013/14. From quarter one to quarter three in 2015/16 the trust received 70 written complaints.

Well Led

- The sickness and absence rate varied between approximately 2.5% and 2.2% between January 2013 to January 2015. The sickness rate was consistently better than the England average throughout this period

- In the General Medical Council National Training Scheme Survey the trust scored within expectations for all 14 indicators.
- In the 2015 Staff survey the trust scored in the top 20% of all trusts for 18 and in the bottom 20% for five of the 32 questions.

Inspection history







- The Royal Brompton Hospital was inspected in February and August 2013 and was compliant with the standards and regulations we inspected against at that time.

Our ratings for this hospital

Our ratings for this hospital are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Outstanding	Outstanding	Good	Good	Good
Critical care	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Good	Good	Good	Good
Outpatients and diagnostic imaging	Good	Not rated	Good	Requires improvement	Good	Good
Overall	Good	Good	Good	Good	Good	Good

Medical care

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

Information about the service

The Harefield Hospital serves both a local and national population. The hospital is a specialist heart and lung hospital known both locally and internationally as a treatment centre for people with heart and lung disease. The medical services at Harefield Hospital include two inpatient wards Oak and Acorn with a total of 50 beds that made up the acute cardiac care unit (ACCU), four catheter laboratories providing primary angioplasty and the Woodlands pre assessment unit.

In the period September 2014 to August 2015 Harefield Hospital admitted 8,700 patients; of these 61% were cardiology cases.

We inspected Oak and Acorn Wards (ACCU), the Woodlands pre admissions unit and the four catheter laboratories.

Information provided by the trust prior to our inspection was reviewed and used to inform our inspection approach.

During the inspection visit we spoke with 12 patients including their family members and carers, 23 staff members including nurses, doctors, consultants, senior managers, therapists, and support staff. We observed interactions between patients and staff, considered the environment and looked at seven care records. To support information provided by staff during the visit, we reviewed documentation and computer based information. We also requested and reviewed additional documentary evidence during and following the inspection.

Summary of findings

Overall we rated the medical care at Harefield Hospital as Good because;

- There was a positive culture of incident reporting and there were established processes for investigating incidents. 'Grand Rounds' took place every week and learning from incidents was one of the topics often talked about. We saw that incidents and mortality was reviewed at the monthly Harefield Quality and Safety Group meetings for heart division and that action points were identified.
- All the wards we visited were visibly clean. Wards had daily cleaning schedules in place, we saw the daily cleaning schedules were up to date and signed. Weekly checks were carried out by a cleaning supervisor.
- The introduction of the electronic prescription system had reduced the number of medication related incidents and promoted the safe prescription and administration of medication.
- Medication was stored securely and controlled drugs were locked in cupboards and checks were always completed to ensure there was enough in stock.
- The hospital used a national early warning score (NEWS) system to identify patients whose condition was at risk of deteriorating. The use of NEWS was audited across the trust between January and March 2015. Recommendations and action plans were put

Medical care

in place following the audit to address areas highlighted in the audit which included dissemination to senior nurses, raising staff awareness and training.

- Although the wards had vacancy rates of 18.14 whole time equivalents, we observed staffing levels were in line with planned staffing levels. Staffing levels were tracked throughout the day and nursing staff would be moved across the division as needed.
- Multidisciplinary working underpinned the care provided to patients. Consultant led multidisciplinary board rounds were held on a daily basis Monday to Sunday on Oak and Acorn ward attended by the nurse in charge, clinical nurse specialists and medical staff.
- Care was provided in line with NICE guidelines. New NICE guidelines were presented to the standards committee and NICE quality standards were reviewed.
- The audit programme was formalised and there was a programme of current audits being undertaken. The Heart division contributed to clinical audits e.g. Medication used for secondary prevention after PCI. This data came from the MINAP database which can be tailored to provide local information.
- A pain scoring system was used with patients across the wards. Staff had access to the pain management team which was led by a consultant anaesthetist which was available for patients for both chronic and acute pain.
- Patients' nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition.
- Nursing staff had access to practice educators and ward based mentors. New staff were supernumerary on the wards for the first three weeks and received clinical supervision. Nurses told us there were opportunities for learning and development and they could access training online. The practice educators held study days to assist nursing staff with their Nursing & Midwifery Council (NMC) revalidation.

- Staff had access to allied health professionals such as speech and language therapists, dietitians, tissue viability specialist, physiotherapists and clinical nurse specialists.
- There were many thank you cards on display in Oak and Acorn wards demonstrating the gratitude of previous patients and their relatives and results from the 'Friends and Family Test' showed people would recommend the medical services provided by the hospital.
- Patient confidentiality was maintained by staff during handovers, multidisciplinary meetings and ward rounds. Nursing staff were allocated to specific bay and signs were in place to ensure patients were aware which nurse was caring for them. Patients told us their privacy and dignity was preserved at all times and care we saw supported this.
- All feedback from patients and their relatives was complimentary about the care they received on the medical wards; they told us staff were kind and tried to make them feel comfortable. Patients told us staff came quickly when they used the call bell.
- Patients were offered pre assessment clinics by telephone as the hospital provided services to patients from the local area and nationally.
- The hospitals transport department provided services to patients across the UK and patients were admitted as emergencies via the primary angioplasty service from East of England through to East Berkshire and at times from the local airports.
- During the period February 2015 to January 2016, 80% (10,728) of patients experienced no ward move.
- Patients admitted over the age of 75 years were screened for dementia within 72 hours of admission for dementia.
- There was a complaints policy in place and staff knew how to access it. Staff understood how to manage complaints locally and who to refer to for resolution or escalation. Contact details for Patient Advocate and Liaison Service (PALS) were visible across the hospital.

Medical care

- The service was led by experienced clinicians with autonomy in decision making and a clear strategy for the service in place.
- There was suitable governance arrangements in place Clinical directors felt they were supported and described being supported top down and bottom up in shaping their services.
- There was evidence of engagement with the public and staff members. Staff were encouraged to develop ideas which could improve the quality and / or efficiency of the trust's services.
- There was a positive culture across the Heart Division, managers were supportive and approachable. Staff also had opportunities for personal development and felt respected and valued.

However

- Hand gel was not clearly indicated which meant that staff or visitors may find it hard to find at the entrance to the wards/clinical areas. Hand hygiene audit undertaken in the cath lab for the period July 2015 to March indicated that medical staff and allied health professionals scored below the trust target of 90%.
- Compliance with mandatory training was below the trusts target of 75% for medical staff and allied health professionals.
- There was no on site pharmacy service available from 1pm on Saturdays and all day Sunday, this was covered by an on call service.
- During the period April 2015 to March 2016 the trust was below the England standard of 92% for referral to treatment (RTT) for Cardiology (88%).
- During the period September 2014 to August 2015 the average length of stay for elective patients in cardiology at Harefield hospital was higher (3 days) than the England average (1.9 days).

Are medical care services safe?

Good



We rated safety for medical care as Good because;

- There was a positive culture of incident reporting and there were established processes for investigating incidents. Grand rounds took place every week and learning from incidents was one of the topics often talked about. We saw that incidents and mortality was reviewed at the monthly Harefield Quality and Safety Group meetings for heart division and that action points were identified.
- All the wards we visited were visibly clean. Wards had daily cleaning schedules in place, we saw the daily cleaning schedules were up to date and signed. Weekly checks are carried out by a cleaning supervisor.
- The introduction of the electronic prescription system had reduced the number of medication related incidents and promoted the safe prescription and administration of medication.
- Medication was stored securely and controlled drugs were all locked in cupboards and checks were always completed to ensure there was enough in stock.
- The hospital used a national early warning score (NEWS) system to identify patients whose condition was at risk of deteriorating. The use of NEWS was audited across the trust between January and March 2015. Recommendations and action plans were put in place following the audit to address areas highlighted in the audit which included dissemination to senior nurses, raising staff awareness and training.
- Although the wards had vacancy rates of 18.14 whole time equivalents, we observed staffing levels were in line with planned staffing levels. Staffing levels were tracked throughout the day and nursing staff would be moved across the division as needed.

However;

- Hand gel was not clearly indicated which meant that staff or visitors may find it hard to find at the entrance to the wards/clinical areas. Hand hygiene audit undertaken in the cath Lab for the period July 2015 to March indicated that medical staff and allied health professionals scored below the trust target of 90%.

Medical care

- Compliance with mandatory training was below the trusts target of 75% for medical staff and allied health professionals.

Incidents

- There were no never events for the period March 2015 to March 2016. 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.
- There were two serious incidents reported between April 2015 to March 2016, we saw that lessons learnt and changes in practice had been identified. Staff on the wards were aware of the incidents and were able to tell us how their practise had changed.
- Between March 2015 and May 2016 medical services reported 259 incidents that were reported via the trust incident reporting system. 250 were classed as either no harm or minor harm. This meant that the incident resulted in low or no harm to the patient. The most common incidents reported related to patient falls (44) and medication errors (49).
- An online computer incident reporting system (DATIX) was used to report incidents and staff told us it was easy to report incidents when they occurred.
- Staff in the catheterisation laboratories (cath lab) told us that incidents were discussed at staff meetings across site with the Royal Brompton Hospital (RBH) quarterly and in staff meetings monthly. Staff were able to tell us lessons learnt from incidents and actions taken to prevent a reoccurrence. Nursing staff on the wards told us that they were encouraged to report incidents and felt there was a good culture in reporting. A catheterisation laboratory or cath lab is an examination room in a hospital with diagnostic imaging equipment used to visualize the arteries of the heart and the chambers of the heart and treat any stenosis or abnormality found.
- Grand rounds took place every week and learning from incidents were one of the topics often talked about. Grand rounds are formal meetings for doctors with clinical nurse specialists and nurses in attendance. The objective was to discuss issues and learning.
- Harefield hospital provided regular patient safety bulletins to staff which provided information about incidents of relevance to the wider hospital community.

- We saw that incidents and mortality was reviewed at the monthly Harefield Quality and Safety Group meetings for heart division and that action points were identified.
- The Directorate of Governance and Quality reviewed the deaths that had occurred within the cardiology on a monthly basis, minutes which showed that the management of patients was scrutinised and identified for further discussion at MDT meetings. This meant that action points and lessons learnt were identified.

Duty of Candour

- From November 2014, NHS providers were required to comply with the Duty of Candour Regulation 20 of the Care Quality Commission (Registration) Regulations 2014. The duty of candour is a regulatory duty that rates openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain notifiable safety incidents and provide reasonable support to that person.
- Minutes of the Heart Division's Quality and Safety Group demonstrated that compliance with duty of candour was reported when responding to patients and or their relatives when investigating incidents.
- Most staff were aware of their responsibilities under Duty of Candour, which ensured patients and / or their relatives were informed of incidents that had affected their care and treatment and they were given an apology. Ward managers and staff were able to give us an example of when relatives had been spoken to following a patient fall.

Safety thermometer

- The NHS safety thermometer is an improvement tool to measure patient "harms" and harm free care. It provides a monthly snapshot audit of the prevalence of avoidable harms in relation to new pressure ulcers, patient falls, venous thromboembolism (VTE) and catheter-associated urinary tract infections.
- Between March 2015 and March 2016 the trust identified 19 pressure ulcers, three falls with harm and three catheter acquired urinary tract infections (C.UTI's) reported.
- Safety Thermometer results were displayed on the wards, which meant this information was available to patients and their families.

Medical care

- Nursing staff advised that all patients were given non-slip socks and that as part of the care pathway patient would be risked assessed for example falls.
- We saw that the wards safety thermometer reporting was discussed at the monthly Harefield Quality Safety Group for the heart division meetings and that action points were identified.

Cleanliness, infection control and hygiene

- We looked at the results of the patient led assessments of the care environment (PLACE) 2015. The trust scored 97% for cleanliness which was similar to the England average 98%.
- All the wards we visited were visibly clean. We observed support staff cleaning throughout the day and undertaking this in a methodical and unobtrusive way. Wards had daily cleaning schedules in place, which staff would tick to indicate when specific areas had been cleaned. We saw the daily cleaning schedules were up to date and signed. Weekly checks were carried out by a cleaning supervisor. Any spillages or urgent problems were reported by telephone and cleared within 30 minutes.
- Cath labs were clean and spacious and had been designed to enable them to be deep cleaned regularly.
- We observed green 'I am clean' labels were in use to indicate when equipment had been cleaned.
- The trust reported no incidents of Meticillin-resistant staphylococcus aureus (MRSA) for the period September 2015 to February 2016. Patients were swabbed for meticillin-resistant staphylococcus aureus (MRSA) on admission and treatment was commenced if indicated. No cases of MRSA were identified across the medical wards.
- Hand gel was available for use at the entrance to the wards/clinical areas, within the wards at the entrance to bays and side rooms. However we found that the hand gel was not clearly indicated which meant that staff or visitors may find it hard to find. We observed staff generally washed their hands in line with the World Health Organisations (WHO) guidance "Five moments of Hand Hygiene." Hand hygiene audits showed for the period July 2015 to March 2016 demonstrated that on Acorn and Oak wards nurses, medical staff and allied health professionals (AHP) scored 100%. However in the cath labs for the period July 2015 to September 2015 nurses scored 90%, medical staff 56%, AHP 72%, for the period October 2015 to December 2015 nurses scored 94%, medical staff 80%, and AHP 76% and for the period January 2016 to March 2016 nurses scored 95%, medical staff 87%, AHP 86%. Throughout this nine month period medical staff and AHP working in the cath labs scored below the trust target of 90%.
- Adequate supplies of personal protective equipment (PPE) were available and we saw staff using this appropriately when delivering care. We noted all staff adhered to the "bare below the elbows" trust policy in clinical areas. Bare below elbow audits undertaken between July 2015 to March 2016 demonstrates that Acorn and Oak wards and cath labs scored were 100%.
- Side rooms were used to care for patients where a potential infection risk was identified. This was to protect other patients from the risk of infection. Signs were in place at the entrance to side rooms which were being used for isolating patients, giving clear information on the precautions to be taken when entering the room.
- We observed clinical and domestic waste was appropriately segregated and there were arrangements for the separation and handling of high risk used linen. We observed staff complied with these arrangements.
- We observed sharps management complied with Health and Safety (Sharp Instruments in Healthcare) Regulations 2013. We saw sharps containers were used appropriately and they were dated and signed when brought into use.
- We saw that infection control was discussed at the monthly Harefield Quality Safety Group for heart, anaesthesia and critical care division's clinical governance meetings and that action points were identified.
- Infection and Prevention Control training formed part of the mandatory training programme and was updated yearly. The trusts target was 75% of staff having completed the training. Within the heart division 53% of medical staff, 72% of nursing staff and 59% of allied health professionals had completed the training. This was below the trusts target.

Environment and equipment

- We found each clinical area had resuscitation equipment stored on resuscitation trolleys and emergency grab, readily available. The equipment was

Medical care

checked daily, fully stocked and ready for use. Ward staff advised that audits highlighted that that daily checks were not being done consistently and that at hand over the staff member responsible for the trolley check did a verbal handover.

- We observed ward bays and corridors were generally kept clear of equipment, therefore avoiding trip hazards so people were kept safe from avoidable harm.
- The trust undertook health and safety risk assessments. The risk assessment undertaken in March 2015 showed that four out of 54 hazards, fire, lighting, work equipment and workplace required further control to reduce the risks.
- We saw that all Electrical Medical Equipment (EME) had a registration label affixed and was maintained and serviced in accordance with manufacturer's recommendations. We also saw safety check labels were attached to electrical systems showing they had been inspected and were safe to use.
- Health and safety was part of the statutory training programme, which staff were required to attend. The trusts target was 75% of staff having completed the training. Within the heart division 65% of medical staff, 90% of nursing staff and 87% of allied health professionals had attended training for health and safety. The number of medical staff completing the training was below the trust target.

Medicines

- Medications were prescribed, stored and administered using hospital policy and guidelines.
- Medications were prescribed and administered via a password protected electronic prescribing system called "Medchart". Senior staff told us that the roll out of the electronic prescribing had been completed recently. The benefits of the new system had been acknowledged as nurse found documentation clearer which had reduced errors linked to handwriting and recording. The focus was now on missed medicines, which had already been reduced.
- Medicines were stored in lockable cupboards within locked treatment rooms.

- Some medicines were stored in dedicated, lockable fridges. We saw documented evidence that the temperature of these fridges were checked daily.
- Controlled drugs (CDs) were stored in lockable wall cupboards. There was evidence of daily controlled drug checks on Oak and Acorn ward.
- Phlebotomists were based on the wards we saw that their trolleys were stored securely and locked. Phlebotomists collect blood samples from patients to help diagnose illness.
- On the pre assessment unit, medical supplies cupboard had a keypad entry but was unlocked. There was a locked medicines cupboard in the treatment room.
- Inpatient prescription pads were kept in a locked cupboard on the pre-assessment unit. Prescriptions were made out in the unit by either a prescribing pharmacist or the nurse consultant. Drugs were all dispensed by the pharmacy within the hospital.
- Keys to the medicine cupboard and the prescription pad cupboard were kept in a key safe in the office of the clinical nurse specialists (CNS).
- Pharmacy services were available six days per week, with reduced hours on a Saturday from 10.00am to 1pm. There was no on-site service on a Sunday. An on call pharmacy service operates outside the pharmacy working hours, for advice but in some circumstances, pharmacists would travel to the relevant site to supply urgently needed medicines.
- Medicines management was part of the training programme for some staff. Within the heart division 33% of medical staff, 68% of nursing staff had attended training for medicines management training.

Records

- We reviewed seven sets of patient records and saw patients care plans included all identified care needs and were completed. Patient records contained a range of risk assessments including; pressure assessment within six hours of admission, Venous Thromboembolism (VTE) checks, nutritional and falls risk assessment.
- Patients' medical notes (hard copies) were stored in lockable trolleys and nursing records were kept at patient's bedside.

Medical care

- Medical staff had access to electronic patient records (EPR), so they were able to order tests and look at results and images. The computers were on trolleys based on the ward; this meant that the doctors were able to take the computer to the patients' bedside to refer to their results when in consultation.
- Staff told us that the electronic records contained all updates to a patient's records and contained all relevant patient information from pre-assessment to discharge.
- Details of any decisions made at MDT meetings were uploaded to the patient's EPR and the patient was copied in.
- On the pre assessment unit medical notes were held in a store room. Staff told us that notes were almost always available when needed. Documentation of clinical data is recorded on paper records and any telephone communication was noted on the electronic patient record (EPR). Any correspondence following a pre - assessment was typed by the CNS onto the EPR and a hard copy was posted to the patient and their GP.
- Information Governance was part of the mandatory training programme which all staff were required to attend. The trusts target was 75% of staff having completed the training. Within the heart division 100% of medical staff, 77% of nursing staff and 75% of allied health professionals had attended the training.

Safeguarding

- Staff had access to the trust's safeguarding policy via the trust intranet and knew how to access the safeguarding team to provide advice and guidance when required. Staff told us this team was very supportive in giving advice and assisting them when concerns were raised or information was required.
- Safeguarding information, including contact numbers of the trust lead were kept on the wards in folders and on staff notice boards, and staff were aware of how to access this. Safeguarding concerns were also discussed at handover, which ensured all staff were aware of ongoing concerns.
- Staff were able to identify the potential signs of abuse and the process for raising concerns and making a

referral. We were given examples of concerns they had identified and referrals made. Staff told us they occasionally received feedback on the outcome of referrals.

- Safeguarding adults and children was part of the mandatory training programme for staff and different levels of training were provided according to the job role. The trusts target was 75% of staff having completed the training. Within the heart division 61% of medical staff had attended safeguarding adults level one, 67% had attended safeguarding children level one and 51% had attended level two safeguarding children. 74% of nursing staff and 75% of allied health professionals had attended safeguarding vulnerable adult's level one. 89% of nursing staff and 67% of allied health professionals had attended safeguarding vulnerable children level one and 89% of nursing staff and 50% of allied health professionals had attended safeguarding vulnerable children level two.

Mandatory training

- Staff were aware of the mandatory training they were required to undertake.
- The mandatory and statutory training programme covered basic life support, equality and diversity, fire safety, health and safety, infection control, information governance, moving and handling patients and loads, safeguarding children level one, two and three and safeguarding adults level one, medicines management, medical gas, information governance, and prevent.
- Ward managers we spoke with demonstrated the systems they used locally to monitor their staff attendance at mandatory training to ensure it was completed, or refreshed.
- The trusts target for staff having completed their mandatory and statutory training was 75%. At the time of our inspection, compliance with mandatory training for the heart division was 54% for medical staff, 78% for nursing staff and 63% for allied health professionals. Compliance with mandatory training was below the trusts target for medical staff and allied health professionals.

Assessing and responding to patient risk

- Patients' clinical observations such as pulse, oxygen levels, blood pressure and temperature were monitored

Medical care

in line with NICE guidance CG50 'Acutely Ill-Patients in Hospital.' A scoring system known as a national early warning score (NEWS) system was used to identify patients whose condition was at risk of deteriorating. The electronic system allowed early warning scores to be automatically calculated within the e-noting electronic record system. The system was accessible from any computer terminal in the trust. The system also had built in alerts if readings were outside expected ranges, enabling speedy response and re-assessment of care. Staff also told us that they attended alert training for spotting the deteriorating patient.

- The use of NEWS was audited across the trust between January and March 2015. On Oak and Acorn wards a total of 196 patients observation charts were reviewed. The audit checked that staff were recording on the correct forms, that NEWS scores were being recorded and that they were accurate. The monthly audit's showed the number of patients not being escalated to the SHO had reduced over the three month period. Recommendations and action plans were put in place which included dissemination to senior nurses, raising staff awareness and training. We observed that NEWS was being used effectively.
- Ward staff attended three daily safety handovers which were used to identify patients who were acutely unwell and at risk. The ward used a 6 point acronym of SAFETY to remind staff of the areas to be covered:
 - S – side rooms
 - A – acutely unwell
 - F – falls risk
 - E – end of life care
 - T – trolley checks
 - Y – psYchology
- Staff in the cath labs utilised the World Health Organisation (WHO) safety surgery checklist for every patient. We saw that these were completed appropriately. The WHO checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of perioperative care.
- Included in the intergarted care pathways were risk assessments in key safety areas using nationally

validated tools. For example the risk of falls was assessed, patients handling was risk assessed and pressure damage was assessed using the waterlow score.

- Risk assessments were done pre - admission and on admission. Patients with pressure ulcers were referred to the tissue viability nurse and we saw that correct equipment for example an air mattress was in place for the patient. We observed risk assessments were reviewed daily and where required, care plans had been updated with appropriate risk management actions.
- Basic life support was part of the mandatory training programme for nursing staff to attend. The trust's target was 75% of staff having completed the training. Within the heart division was 70% for medical staff, 86% for nursing staff and 62% for allied health professionals. Basic life support training was below the trust's target for medical staff and allied health professionals.

Nursing staffing

- The vacancy rates on Oak and Acorn wards were 18.14 whole time equivalents (WTE). For qualified nursing staff the established staffing levels was 69.54 WTE however the actual was 54.49 WTE. The largest number of vacancies were band six nurses (8.11 WTE) and band five nurses (6.36 WTE). The wards also had 3.46 WTE vacancies for unqualified nurses.
- The main concern for senior staff across the division was a lack of band 6 nurses. Senior nursing staff told us that they struggled to recruit band six nurses and had over recruited band five nurses to compensate. The trust had recently recruited staff from Italy, Spain and Portugal who were due to start later in the year. Recruitment of band six nurses was documented in the minutes of the Cardiology working group.
- Information on the bank and agency staff usage for heart division was provided by the trust for 1 April to 30 June 2016. During this period 32.52 WTE agency and 42.75 bank staff were used across the division. However staff on Oak and Acorn wards told us that the use of agency staff was low about 5% and mostly used bank staff from within the trust about 10-15%. The wards tended to use the same agency staff; all agency staff were orientated on the wards and were trained on the trusts IT systems.

Medical care

- The numbers of staff planned and actually on duty were displayed at ward entrance in line with guidance contained in the Department of Health Document 'Hard Choices'. On the wards we visited we observed staffing levels were in line with planned staffing levels. Depending on the ward, nurses were attached to bays or allocated to specific patients. The planned nurse to patient ratio for the wards were 1:6 patients in bay areas and 1:4/5 if patients are nursed in side rooms. Nursing staff also had assistance from health care assistants (HCA's). Due to acuity of patients nursing levels are generally the same for night and day. Ward sisters were supernumerary to the agreed staffing levels so that if required, they could support ward staff if patient acuity or occupancy increased. Staff reported that the manager of bank staff came to the wards to check staff levels.
- Staff that provided one to one support for patients (specials) were not counted in the staffing levels. HCA's were specifically trained as 'specials' to support patients who had complex needs. We observed specials sitting with patients to ensure they did not fall out of the bed. The number of specials was reviewed daily and patients' needs assessed for so the wards could safely manage the risk.
- Staffing levels were determined using an acuity tool to determine safe staffing levels acuity audits are undertaken twice a year.
- Senior nurse managers were available on call out of hours.
- One consultant is on call for ward cover from 0900 on Saturday to 0900 on Monday. There was a nominated consultant on a weekly rota to look after patients in the wards. Additional advice can be sought by junior staff from any other consultants who may have been more directly involved in the care of any individual inpatient. There were daily consultant or registrar ward rounds. Medical staff told us, 'the team is very friendly' and consultants are very approachable'.
- The cardiology SHOs look after patients on Oak ward with 32 beds and a high turnover of patients. Sicker patients are generally looked after on Acorn ward which has 18 beds with the facility to care for Level 1 and Level 2 patients. There are generally two SHOs based on Oak ward and one SHO based on Acorn ward. An additional SHO is dedicated to the primary PCI service by day. The duties of SHO staff include ward work with patient review and arranging and reviewing tests. Medical staff told us that 'it's a great job if fully staffed, stretched when there are gaps in the rota because of sickness and holidays.'
- SHOs rotated between the different cardiology teams every 4 months.

Major incident awareness and training

- Staffing levels were determined using an acuity tool to determine safe staffing levels acuity audits are undertaken twice a year.
- Senior nurse managers were available on call out of hours.
- The proportion of consultants was slightly higher than the England average, middle career doctors was 4% less, registrar's 21% more and junior doctor's 21% less than the England average. There was no foundation level medical staff (F1 and F2) at Harefield Hospital.
- Consultant led speciality services provided 24/7 cover supported by specialist registrars. The rota covered by medicine at Harefield Hospital included Harefield Heart Attack Centre, transplantation medicine.
- Ward consultant cover is provided on weekdays by one consultant from 0800 to 1700. There is a duty PPCI consultant rota from 1700 to 0800, and the consultant must be within 20 minutes of the hospital.
- The hospital had an emergency planning officer for the site. The trust business continuity plan set out the level of escalation and response required.
- Staff told us that the trust has CRRISIS simulation training that operated across site.
- The trust did not have formal major incident training in place. However, we observed the major incident awareness forum on the trust intranet and found it to contain key policies and the names and contact details of key trust staff.
- Fire safety training was part of the statutory training programme, which staff were required to attend. The trusts target was 75% of staff having completed the training. Within the heart division 65% of medical staff, 92% of nursing staff and 87% of allied health professionals had attended training.

Are medical care services effective?

Medical care

Good



We rated the effectiveness of medical care as Good because;

- Multidisciplinary working underpinned the care provided to patients. Consultant led multidisciplinary board rounds which were held on a daily basis Monday to Sunday on Oak and Acorn ward attended by the nurse in charge, clinical nurse specialists and medical staff.
- Care was provided in line with NICE guidelines. New NICE guidelines were presented to the standards committee and NICE quality standards were reviewed
- The audit programme was formalised and there was a programme of current audits being undertaken. The Heart division contributed to clinical audits e.g. Medication used for secondary prevention after PCI. This data came from the MINAP database which can be tailored to provide local information.
- A pain scoring system was used with patients across the wards. Staff had access to the pain management team which was led by a consultant anaesthetist which was available for patients for both chronic and acute pain.
- Patients' nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition.
- Nursing staff had access to practice educators and ward based mentors. New staff were supernumerary on the wards for the first three weeks and had access to clinical supervision. Nurses told us there were opportunities for learning and development and they could access training online. The practice educators held study days to assist nursing staff with their Nursing & Midwifery Council (NMC) revalidation.
- Staff had access to allied health professionals such as speech and language therapists, dietitians, tissue viability team, physiotherapists and clinical nurse specialists.

Evidence-based care and treatment

- The wards provided care in line with National Institute of Health and Care Excellence (NICE) Guideline - CG50 -

that covers recognising and responding to deteriorating patients. Staff used a national early warning score (NEWS) to identify deteriorating patients and ensured they were escalated to the medical team.

- The PCI policies were based on NICE guidelines, these were reviewed annually and amended if appropriate and modified where necessary for local use.
- The standards committee met quarterly and had responsibility for cardiology, cardiac surgery, transplant surgery and chest medicine and surgery. New NICE guidelines were presented and NICE quality standards were reviewed, for example a recent audit has looked at lipid levels and compliance with statin treatment.
- Clinical staff advised that the medical divisions also referred to international guidelines and that the consultants would educate the junior medical staff as to which guidelines they should follow.
- We looked at four sets of guidelines and found that they were named, dated, and within the documented expiry date. There was an embedded process in the audit database for policy review before the due date. Guidelines were updated regularly. An example was given of a new drug which would be discussed between medical, nursing and pharmacy staff at a medical management meeting before seeking formal approval of the Trust. The relevant Trust policy would then be updated. Any proposed treatment outside the guidelines would be formally presented and discussed.
- The audit programme was formalised and there was a programme of current audits being undertaken. The audit data was entered into the relevant databases by nurses, cardiac physiologists, and medical staff. We reviewed four audits from the hospital audit programme:
 - Medication used for secondary prevention after PCI. This data came from the MINAP database which can be tailored to provide local information.
 - Annual audit of adherence to NICE guidelines for antiplatelet drug treatment post PCI. The results were good with no specific action needed.
 - Compliance with NICE lipid treatment guidelines post PCI. The NICE guidelines have been adapted because of concerns over the side effects of long term high dose treatment with atorvastatin 80mg daily. Clinical data was re-audited annually.

Medical care

- Compliance with NICE heart failure guidelines was good apart from referrals for palliative care. This was audited annually.

Pain relief

- A pain scoring system was used with patients across the Oak and Acorn wards. The scale asked patients to rate their pain level between one (no pain) and ten (very bad pain). We saw evidence that patients were usually asked about their level of pain and this was documented alongside the routine patient observations.
- Staff had access to the pain management team which was led by a consultant anaesthetist which was available for patients for both chronic and acute pain. Anaesthetists provided cover out of hours.
- Patients medicine records demonstrated that as required medicines were prescribed for pain relief.

Nutrition and hydration

- Patient led assessments of the care environment (PLACE) 2015 showed that the trust scored 90% for facilities which was higher than the England average of 88%.
- Patients' nutritional needs were assessed using the Malnutrition Universal Screening Tool (MUST) as recommended by the British Association for Parenteral and Enteral Nutrition. We saw that scores were recorded, and risks identified.
- We spoke with catering staff on the wards who told us that they were given daily lists of patients' dietary needs and any restrictions.
- Patients selected their food choices from prepared menus that provided a choice of foods. The menus had been designed to include a range of special diets, high energy, soft, gluten free, high fiber, vegetarian, halal and healthy eating options.
- Patients were reviewed by a dietician if there were concerns with their weight or food intake. Dietary supplements such as fortified milkshakes were given to patients who needed a higher calorie intake.
- Drinks were left within reach and patients were given assistance to drink if required.
- On the wards patients were offered sufficient quantities of fluids with a variety of hot and cold drinks available

throughout the day including early morning and last thing at night. This meant that the wards were working to "The Quick Guide to the Government's Healthy Eating Recommendations" 2014 states people should Drink between six to eight glasses (about 1.2 litres) of water, or other fluids, every day, to avoid dehydration.

- On the pre-admission unit tea, coffee, water and biscuits were available in the waiting area. A lunch time snack box was available for patients who were undergoing a pre admission assessment over several hours.

Patient outcomes

- Harefield Hospital participated in the Myocardial Ischemia National Audit Project (MINAP), which is a national clinical audit of the management of heart attack. In 2012/13 and 2013/14 the hospital scored better than the England average in two of the three standards audited for care of patients with non-ST-elevation infraction (nSTEMI).
- Harefield Hospital participated in the 2013/14 National Heart Failure Audit and scored higher than the England average in all four standards audited for clinical practice for in hospital care. The hospital also scored better than the England average in clinical practice for discharge the hospital in five of the seven standards audited and similar to the England average in one of the five standards.
- Between August 2014 and July 2015 the standardised risk of re-admission for cardiology was higher than the England average for elective admissions and lower than the England average for cardiology for non-elective admissions. This means there were less observed readmissions than expected.
- The trust did not take part in the Sentinel Stroke National Audit Programme (SSNAP) or the National Diabetes Inpatient Audit (NaDIA) due to the specialised cardiothoracic nature of the treatment it provides.
- Harefield hospital is consistently in the top 5 hospitals for its primary angioplasty 'door to balloon' time of 33 minutes.

Competent staff

Medical care

- Throughout our inspection we observed staff were professional and competent in their interactions with colleagues, patients and their relatives/carers.
- Staff told us they participated in the appraisals process and that it was useful to focus on learning objectives. Staff working on Oak and Acorn wards told us that the appraisals were undertaken with the deputy ward sister and the practice nurse educator would identify further training. We requested information on appraisal completion for Oak and Acorn ward from the trust but it was not provided.
- Nursing staff told us that they attended a trust induction programme which included the trust values.
- New nursing staff had access to practice educators and ward based mentors. New staff were supernumerary on the wards for the first three weeks and had access to clinical supervision. Staff were provided with a Trust hand book and information for orientation. New staff were also required to complete an eight week development book.
- Nurses told us there were opportunities for learning and development and they could access training online. On the wards we observed a teaching session for staff on the ward provided by the palliative clinical nurse specialist (CNS) on T34 McKinley syringe pump training. The interaction between the staff and the CNS was good. Staff attending the training session had to show they were competent in the use of the syringe pump.
- The practice educators held study days to assist nursing staff with their Nursing & Midwifery Council (NMC) revalidation. Nurses informed us that they had felt supported through their revalidation.
- Health care assistants (HCA) had to complete the care certificate. The care certificate is knowledge and competency based and sets out the learning outcomes and standards of behaviours that must be expected of staff giving support to clinical roles. One HCA we spoke with told us that had worked at the hospital for 6 months and had completed their care certificate.
- On wards nursing staff were identified as champions for example dementia and tissue viability which meant that they would be a resource for their colleagues providing advice and guidance.
- The Trust provided English classes for newly appointed nurses from abroad where English was not their first language.
- The Trust had implemented a Band 5, 18 month rotation programme offering candidates the opportunity to work in 3 different areas in the Trust. They have their own Practice Educator with training days provided throughout the rotation.
- Junior doctors working in the cath labs told us that they had monthly 'wet lab' and simulation training sessions that included critical risk management.
- Junior doctors we spoke with reported that they were inducted into the trust and the hospital provided good training opportunities and were given time for training; they also had good support from consultants who also provided clinical supervision.

Multidisciplinary working

- Medical and nursing staff of all grades that we spoke with all described good working relationships between healthcare professionals. Medical staff told us that multidisciplinary working underpinned the care provided to patients. We observed the healthcare team worked well together to provide care to patients.
- Consultant led multidisciplinary board rounds were held on a daily basis Monday to Sunday on Oak and Acorn ward attended by the nurse in charge, clinical nurse specialists and medical staff. Patients care and treatment were reviewed with actions being taken being taken to progress care.
- The weekly MDT meeting across all the cardiac specialities included discussion of every inpatient and any outpatient for whom a decision was needed and were also attended by physio and occupational therapists and social workers. Where allied health professionals had been involved with patients they had recorded this in the patient records.
- Ward staff told us that they had access to the palliative care team that provided support five days per week and they worked closely with the heart failure nurses and the complex discharge teams.
- Staff in the cath labs told us that they had weekly cross site MDT's included nurses and infection control nurse.

Medical care

- Outcomes from MDT meetings were uploaded into the patient's electronic medical records which medical staff could access across site which meant that doctors could see all the information.
- Twice a year the trust held clinical nurse specialist meetings from the Royal Brompton and Harefield Hospital. Matrons and sisters also had regular cross site meetings.
- There was pharmacist support on the wards and they provided information to patients on their medications and medication usage.

Seven-day services

- A consultant was available for to provide telephone support or to review patients seven days per week to ensure they received suitable treatment, whatever day of the week they were admitted. During the week and at weekends ward rounds were consultant led.
- At night and weekends there is one SHO covering Oak and Acorn wards, the transplant ward, and the primary PCI service. One middle grade registrar provides cover for primary PCI and the wards between 8.00am and 8.00pm and there is a registrar resident in the hospital at night.
- At weekends by day there was a registrar on duty in the hospital from 8.00am to 8.00pm; and a second from 8.00am to 1.00pm to cover ward rounds. One SHO from 8.00am to 8.00pm and a second from 8.00am to 5.00pm. One registrar and one SHO were resident at night.
- The wards had access to a full range of allied health professionals six days a week. This included; dietitians, speech and language, occupational and physiotherapists and psychologists. Physiotherapists also provided an on call service at the weekends.
- Staff reported there was seven day availability of all diagnostic services including imaging, and laboratory facilities. They told us they did not encounter any problems with diagnostic services out of normal working hours.
- The cath labs provided elective services on Monday to Saturdays and an on call service for out of hours and weekends. Staff told us that they had a day off prior to being on call.

- Pharmacy services were provided Monday to Friday service within normal working hours. There was a ward pharmacist on a Saturday from 10.00am until 1.00pm. There was an on call service out of hours and at the weekends.

Access to information

- Staff told us patient medical notes could be accessed quickly when needed. The ward clerks were responsible for locating and requesting medical notes.
- Patient investigation results were accessible electronically, including blood tests and imaging reports. Staff printed results off and placed them in the patient medical notes.
- Staff had access to national guidance on ward computers which could access internet sites. They told us this was invaluable for accessing NICE guidance and other key reference documents.
- To ensure continuity of staff working on the wards had detailed hand over sheets which they could refer to.
- Staff had access to an online learning management system and trust policies and protocols via the trust intranet.
- Patient's prescriptions were provided via an electronic system that staff could access via a secure login.
- Staff names, roles and photos were on display on wards so that patients and visitors would know which staff worked regularly on the wards.
- On Oak and Acorn wards and in the pre assessment unit there were a variety of leaflets on information related to cardiac diseases.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Mental Capacity Act 2005 (MCA) and Deprivation of Liberties Safeguards (DoLS) training was not part of the mandatory training programme. Staff we spoke with were aware of the requirements of their responsibilities as set out in the Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS). Staff attended training sessions provided by the safeguarding team.

Medical care

- Staff told us they would refer patients to the safeguarding teams if patients required a mental capacity assessment. All DoLS applications were also dealt with by the safeguarding team.
- Patients told us that they had signed consent for their procedures. Staff told us that formal written consent is taken by the consultant involved when the patient is admitted for the procedure.
- Patients told us staff asked their permission before care or treatment was given and medical staff explained their treatment.

Are medical care services caring?

Good



We rated caring for medical care as Good because;

- There were many thank you cards on display Oak and Acorn wards demonstrating the gratitude of previous patients and their relatives and results from the 'Friends and Family Test' showed people between 95% and 100% would recommend the medical services provided by the hospital.
- Patient confidentiality was maintained by staff during handovers, multidisciplinary meetings and ward rounds. Nursing staff were allocated to specific bay and signs were in place to ensure patients were aware which nurse was caring for them. Patients told us their privacy and dignity was preserved at all times and care we saw supported this.
- All feedback from patients and their relatives was complimentary about the care they received on the medical wards; they told us staff were kind and tried to make them feel comfortable. Patients told us staff came quickly when they used the call bell.

Compassionate care

- The trust used the Friends and Family test (FFT) to get patients views on whether they would recommend the service to family and friends. We looked at the latest FFT scores that were available to us and during the period March 2015 to February 2016 the average response rate for Acorn Ward was 29% (252) and Oak wards 21% (503)

which is worse than the England average of 26%.

Overall, these showed satisfaction with the service with the medical wards scoring between 95% to 100% during the period, with Acorn ward scoring 100% in eleven of the twelve months.

- We looked at the results of the patient led assessments of the care environment (PLACE). The trust scored 87% for privacy, dignity and wellbeing which was the similar to the national average of 86%.
- We saw evidence of many thank you cards and letters on display on noticeboards throughout the medical wards. Staff were identified as "kind and caring" and relatives thanked them for looking after their loved ones.
- We observed interactions between staff and patients were professional, kind and friendly. For example, we observed staff explaining to patients what they were doing and always checking if there was anything else they needed. Staff asked patients if they wanted drinks and made sure they were comfortable.
- In the cath labs we observed a patient being prepared for their medical procedure and saw that the patient was treated with dignity and respect.
- Several patients told us they thought the staff were good and caring. Some of the positive comments we received from patients were: "incredibly good", "patient and kind", "delightful", "staff saved my life on at least one occasion", "the staff are amazing".
- The patients we spoke with felt safe in their environment. One patient told us that they felt "very safe; I am in the best possible hands".
- In the CQC national audit inpatient survey the trust scored 9.5 out of 10 for dignity and respect and care from staff. Both results were better compared to most other trusts that took part in the survey.
- Patients told us the nursing staff were respectful to them and every effort was taken to ensure their privacy was protected when personal care was being given.

Understanding and involvement of patients and those close to them

- Patients we spoke with told us they were involved in their care and understood their treatment and care plans. They had frequent opportunities to speak with

Medical care

their consultant and other members of the multidisciplinary team looking after them about their treatment. This enabled patients to make decisions about and be involved in their care.

- Patients described conversations with the doctors and consultants, they had been able to ask questions and had been told how their illness might improve or progress. Positive comments we received were; “doctors explained things to me fully”, “gave me time to ask questions”, “treatment was explained to me”, “the medical staff always explain everything to me”.
- Relatives we spoke to were happy with the care their family member received and felt they had been kept informed of their loved ones’ treatment.
- Patients had nurses allocated to them each day, this meant that staff were able to get to know the patients and were able to that they were introduced to and can ask them any questions they want. We spoke with several nurses who said that ‘we are never so busy that we don’t have the time to explain things to patients’.

Emotional support

- Patients and their relatives told us the clinical staff were approachable and they could talk to staff about their fears and anxieties.
- The hospital chaplaincy service was multi-faith and provided support 24 hours per day. It provided services to patients across the hospital which included Christian and Muslim services which were held across the trust. Staff were aware of how to contact spiritual advisors to meet the spiritual needs of patients and their families.
- A bereavement policy was in place to help staff meet the needs of families at the time of bereavement and to ensure that each case receives the care and support required. PALS & Bereavement Service Officers (PBSO’s) were responsible to run the service and coordinate the service during working hours (Monday to Friday, 9am to 4pm).

Are medical care services responsive?

Good



We rated the responsiveness of medical care as Good because;

- Patients were offered pre assessment clinics by telephone as the hospital provided services to patients from the local area and nationally.
- The hospitals transport department provided services to patients across the UK and patients were admitted as emergencies via the primary angioplasty service from East of England through to East Berkshire and at times from the local airports.
- Patients admitted over the age of 75 years were screened for dementia within 72 hours of admission for dementia.
- Wards had a range of information leaflets available.
- There was a complaints policy in place and staff knew how to access it. Staff understood how to manage complaints locally and who to refer to for resolution or escalation. Contact details for Patient Advocate and Liaison Service (PALS) were visible across the hospital.

However

- During the period February 2015 to January 2016, 20% (2655) of patients experienced no ward move.
- During the period April 2015 to March 2016 the trust was just below the England standard of 92% for referral to treatment (RTT) for Cardiology (88%).
- During the period September 2014 to August 2015 the average length of stay for elective patients in cardiology at Harefield hospital was higher (3 days) than the England average (1.9 days).

Service planning and delivery to meet the needs of local people

- As a specialist hospital Harefield had formal arrangements in place with other NHS trusts to provide a range of support services which included stroke, ear nose and throat, renal and neurological services.
- Harefield hospital offered pre assessment clinics by telephone as the hospital provided services to patients from the local area and nationally as the hospital was

Medical care

also national referral centre for certain specialities. Pre admission assessments were offered in for example angiography, complex devices, and annual transplant patient reviews.

- Visiting times were 3.00pm to 8.00pm every day and visitors were limited to two per bed space. There was a patient rest period on the wards between 1.00pm and 2.00pm; we observed that during this time the lights were turned off on the wards and curtains closed.
- The wards were mixed sex. We saw that male and female patients were accommodated in separate bays.
- We saw there was a discharge lounge located on Oak ward where patients could wait for transport.
- The hospitals transport department provided services to patients across the UK and patients were admitted as emergencies via the primary angioplasty service from East of England through to East Berkshire and at times from the local airports.

Access and flow

- During the period April 2015 to March 2016 the trust exceeded the England standard of 90% for referral to treatment (RTT) for in thoracic medicine (100%) for patients starting consultant led treatment within 18 weeks of referral. However, the trust performance was below the England standard for Cardiology (88%). Further information received from the trust indicates that work began on a remedial action plan in January 2016 to meet the standard of 92% by November 2016.
- During the period September 2014 to August 2015 the average length of stay for elective patients in cardiology at Harefield hospital was higher (3 days) than the England average (1.9 days). The average length of stay for non-elective patients in cardiology at Harefield hospital was higher (6.7 days) than the England average (5.6 days).
- During the period February 2015 to January 2016, 80% (10,728) of patients experienced no ward move, 3% (440) of patients were moved once, 5% (640) of patients were moved twice, 3% (392) patients were moved 3 times and 9% (1,183) patients were moved four or more times. This demonstrates that 20% of patients were not treated in the correct speciality bed for the entirety of their stay.

- Between September 2015 and February 2016 and total of 6 patients were moved on Acorn ward and 32 patients were moved on Oak ward after 10.00pm.
- Between April 2015 and March 2016 there was one reported mix sex breach on Oak ward which occurred in February 2016. This was reported in the clinical quality report.
- Harefield Hospital carried out around 1500 angioplasty (PCI) procedures of which approximately 800 were emergency and 700 elective procedures in the last twelve months.
- Annual numbers of electrophysiological procedures were around 500. Around 6% of elective procedures were cancelled with further appointments being offered within 28 days.
- Pre- admission clinics operate on a daily basis Monday to Friday. These were undertaken by clinical nurse specialists, and pharmacist. Pre - admission clinics were also offered by telephone which meant that patients who had a distance to travel did not need to attend the hospital. Arrangements would be made for the patients' blood and swaps to be undertaken local to where they lived. Staff told us that telephone assessments have 'helped to prevent cancellations.'
- The HCA prepares pre- admission clinic the night before by pre-requesting any necessary tests. Patients arriving at the clinic are identified by the receptionist by name, address and date of birth, and wrist banded which carries a bar code. HCA's check weight, height, blood pressure and pulse, and take MRSA swabs in the treatment room.
- Bed management meetings were held Monday to Friday to update information on bed capacity and respond to bed availability pressures.

Meeting people's individual needs

- We looked at the results of the patient led assessments of the care environment (PLACE) 2015. The trust scored 86% for facilities which was lower than the England average of 90%.
- We saw patients had their needs assessed. We reviewed seven sets of patient records and saw their care plans included all identified care needs.

Medical care

- On Oak and Acorn ward patients who were at risk of fall , who were living with dementia or required extra support were provided with staff who provided one to one care (specials). Patient's families were also encouraged to stay to reassure and or assist patients.
- Staff told us that they received training in dementia awareness and part of this included watching the video call 'Barbara's story' which had been created by another NHS trust to raise awareness amongst staff. Barbara's story is a short film about Barbara and her experiences during a hospital visit.
- Patients admitted over the age of 75 years were screened for dementia within 72 hours of admission for dementia. Across the trust for the period April 2014 to March 2015, 94.6% of patients were being screen for dementia within 72 hours.
- On the wards we observed that toilets, sinks and showers had signage that was dementia friendly.
- We found that patients had access to a range of specialist nurses, for example, heart failure, tissue viability, diabetes, dementia and palliative nurses.
- The Acorn and Oak wards hours which meant relatives could visit their loved ones from 3pm until 8pm. Relatives we spoke with were happy with these visiting times.
- We observed that call bells were answered quickly. Patients told us that staff answered bells straight away and they were never made to feel a nuisance.
- On Oak ward there is a discharge room where patients could wait prior to going home.
- Staff had access to translation services, staff advised that some staff speak different languages and will use them. On the pre-assessment unit staff advised that appointments are sometime postponed because an interpreter could not be found at short notice. We observed staff using picture cards to communicate with a patient whose first language was not English.
- Wards had a range of information leaflets available. This included generic trust information on topics such as infection control, Patient Advice and Liaison Service (PALS), complaints and VTE, plus some relevant

diagnosis/condition specific information on what to do following a heart attack, blood thinning and depression after a stroke. There were no foreign language information leaflets.

- In the cath labs there were large photographs of forests on the ceiling to encourage patients to relax when they had their medical procedure
- In the cath labs a member of staff had been identified as the bereavement champion and staff had received bereavement training.
- The hospital had made a video for patients that provided information about angioplasty.
- The cardiac oncology service works collaboratively with the another NHS trust to offer a 'One stop shop' so that patients had their MRI scan, clinical assessment and ECHO on the same day. This reduced the number of times that patients had to attend the hospital.
- Patients told us that the "Food is good" and there was "always plenty of choice".

Learning from complaints and concerns

- There were a total of nine complaints raised concerning Oak and Acorn wards during the period April 2015 to March 2016. We saw that two complaints were still under investigation, three complaints had not been upheld, one had been partially upheld and three complaints had been upheld. Action points for follow up had been identified.
- Staff told us they tried to resolve complaints and concerns at the time where ever possible. They told us they received feedback about complaints and complaints were discussed at training days.
- The trust provided examples of the investigations and correspondence into formal complaints received. We saw that that patients were given a written apology and provide details of the outcome into the investigation with details of how they contact the Health Service Ombudsman's Office should they not be satisfied with the outcome. We saw complaints were discussed at the monthly Harefield Quality Safety Group for the heart divisions meetings.

Medical care

- There was a complaints policy in place and staff knew how to access it. Staff understood how to manage complaints locally and who to refer to for resolution or escalation. Contact details for Patient Advocate and Liaison Service (PALS) were visible across the hospital.

Are medical care services well-led?

Good



We rated medical care as Good because;

- The service was led by experienced clinicians with autonomy in decision making and a clear strategy for the service in place.
- There was suitable governance arrangements in place. Clinical Directors felt they were supported and described being supported top down and bottom up in shaping their services.
- There was evidence of engagement with the public and staff members. Staff were encouraged to develop ideas which could improve the quality and efficiency of the trust's services.
- There was a positive culture across the Heart Division, managers were supportive and approachable. Staff also had opportunities for personal development and felt respected and valued.

Leadership of service

- The Harefield heart division was led by a divisional director, general manager and a lead nurse.
- Clinical leads reported there was a clear executive structure in the trust which they met with regularly. Clinical directors felt they were supported and described being supported 'top down' and 'bottom up' in shaping their services.
- A good structure was in place to provide support to staff at ward level. Staff told us that the matron had an open door policy and was visible on the wards.
- There was executive patient safety walkabouts every quarter where members of the executive team engage with both staff and patients.

- Staff said managers were supportive and approachable, they also had opportunities for personal development and when they raised concerns they were listened to and their concerns addressed. Staff felt respected and valued.
- Medical staff were also positive about the support they received from Consultants, senior colleagues and their peers who they described as being approachable and supportive.
- Staff told us that across site sister meetings had broadened their understanding of how the two hospitals worked together and had helped to improve communication between the sites.

Vision and strategy for this service

- Staff working on the wards, in the pre-assessment centre and in the cath labs were committed to delivering the trusts vision of being a leading specialist centre for heart and lung disease. Staff were aware that how they contributed to the broader vision and strategy which included assisting in research, providing good care on the wards and in the cath labs treating high number of patients.
- Staff working across the heart division promoted integrated working as staff worked across the different care groups. For example, working collaboratively with the lung division meant some patients care was better coordinated.
- Staff told us that there was joint working between cath labs at Harefield and cath labs at the Royal Brompton site. There were plans for more joint working across the two sites.

Governance, risk management and quality measurement

- The heart division at Harefield hospital was led by a divisional director. There was a lead consultant, a general manager, a clinical service manager and lead nurse on the Harefield site.
- There was a risk register for the heart division which identified one risk which related to delay in assessment for transplant patients due to lack of space and increased activity. The risk had been opened in February 2016 as a moderate risk. Issues with capacity were highlighted by the divisional team.

Medical care

- Heart division quality and safety meetings took place monthly and the risk register was discussed in this meeting.
- Cross site meetings for cath labs were established in February 2016; minutes indicated that the group would report to the cardiology working group and divisional quality and safety group.
- A series of staff meetings and training days depending on their grade and role contributed to the overall governance structure. This included a monthly senior nurse meeting and a bi-monthly deputy sisters meeting. Each division also had care group team away days.
- Staff understood their role and function within the hospital and how their performance enabled the organisation to reach its objectives.

Culture within the service

- Staff were proud to work for the trust; they were enthusiastic about the care and services they provided for patients. They described the trust as a good place to work. Some of the staff we spoke with had worked at the hospital for many years and felt lucky to be working at Harefield Hospital. One staff member told us “I’m convincing myself not to retire - I intended to retire 6 years ago”.
- All staff we spoke to told us that they felt valued and respected.
- Staff said there was an open and transparent culture where people were encouraged and felt comfortable about reporting incidents and where there was learning from mistakes.
- On the wards we saw multidisciplinary working which involved patients, relatives, therapists and nursing staff working together to achieve good outcomes for patients.
- Consultants told us that they were able to draw on the cross site expertise of colleagues.
- There were opportunities for further learning and development, however nursing staff told us “Posts for promotion do not come up often because people stay in their positions for a long time”.

- Patients acknowledged a positive and caring ethos and were happy with their care.

Public and Staff engagement

- The trust had various means of engaging with patients which included surveys such as Friends and Family Tests and other inpatient surveys.
- The ward participated in the compassionate care programme to engage with patients to improve patient experience.
- Staff attended monthly ‘Schwartz Rounds’, staff advised they had been running for about 12 months. Schwartz rounds are an evidence-based forum for hospital staff from all backgrounds to come together to talk about the emotional and social challenges of caring for patients. The aim is to offer staff a safe environment in which to share their stories and offer support to one another.
- Staff told us that the chief executive holds staff forums twice a year. However not all the staff we spoke with had met the chief executive. They told us they received regular newsletters from the chief executive and the ‘In touch’ magazine.
- To develop ideas which could improve the quality and / or efficiency of the trust’s services for the benefit of patients the trust held champion awards twice a year. Staff were nominated by their peers and successful nominations would receive a cash prize and meet the executive team.
- On the wards staff comment cards had been introduced for them to complete at the end of each shift. Staff we spoke with were positive about this.







Innovation, improvement and sustainability

- Oak and Acorn ward staff developed a 6 point patient safety handover. The ward used acronym of SAFETY and won a champion award given by CEO having been nominated by their colleagues.
- Staff ‘enthusing’ audit, a traffic light system on a slip of paper, given to the staff at the end of their shift, allowing them to indicate ‘how their shift was’. On the reverse of the paper are 2 questions, ‘what made your shift good/bad? And what improvements do you think could have helped improve your shift? The Audit was inspired by the advisory board.

Medical care

- The Familial Hypercholesterolemia (FH) team at Harefield has been awarded a grant in a second round of funding from the British Heart Foundation (BHF). Harefield is the only FH centre to be awarded funding in both rounds. FH is an inherited genetic disorder that can cause early heart disease and premature death. The service at Harefield provides regular genetic screening clinics to identify family members with the condition. Following the first round of funding, the team expanded its clinics to other NHS trusts. The new grant has allowed the service to expand into primary care in Slough, East Berkshire and South Buckinghamshire. The team has been named “top recruiter” by the Royal College of Physicians.
- Electronic prescribing had been rolled out across the trust inpatient areas. This has reduced the risk of prescribing errors and support a comprehensive audit trail of medication management initiatives.

Surgery

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

Information about the service

The Harefield Hospital serves both a local and national population. It provides planned and emergency cardiac (heart), thoracic (lung) and cardiothoracic transplant (heart lung) surgery. From September 2014 to August 2015, the hospital carried out over 2,600 operations including lobectomies (surgical removal of the lobe of a lung), mitral valve replacement and repair (heart valve surgery) and heart and lung transplants.

From September 2014 to August 2015, there were 4,906 referrals to the surgical services at the trust. From May 2015 to April 2016 the Harefield Hospital performed over 2,600 operations, of these 41% were cardiac, 45% were thoracic and 13% were cardiothoracic transplants. 86% were elective (planned) and 14% emergency.

The hospital has 168 general and acute beds. Surgical services are provided from a theatre suite with five theatres and four catheter laboratories. These were located on the ground floor of the main hospital building. They were easily accessible for those with mobility issues. Recovery was located bedside the theatre suite. Cardiac and thoracic surgery patients are cared for on Maple ward that has 20 beds with three of these used for high dependency patients. Cedar wards one and two have 25 beds altogether. Day case patients are cared for on the Cherry Tree Day Care Unit, which has 17 beds.

There is a transplant unit with two wards, Fir Tree and Rowan, which have 34 beds in total. The transplant unit provide heart and lung transplants along with insertion and

care of ventricular assist devices (VADs). A ventricular assist device (VAD) is a mechanical pump that is used to support heart function and blood flow in people who have weakened hearts.

We visited the surgical services on Thursday 16 June 2016 and carried out an unannounced visit on Wednesday 22 June 2016.

We visited the surgical pre-assessment area, the surgical wards and main operating theatres. In addition to this, we interviewed service leads and managers of the services. We spoke with 20 members of staff including doctors, nurses, allied health professionals, health care assistants, support staff and administrative staff. We spoke with 16 patients and their family members. We observed patient care and treatment and looked at 15 care records. We reviewed local and national data and performance information about the service.

Surgery

Summary of findings

We rated this service as good because:

- We observed good infection prevention and control (IPC) practices by staff and noted compliance audits completed in this area. Clinical equipment was serviced, clean and functioning. Daily monitoring of resuscitation equipment had taken place in most surgical areas.
- The training information provided by the trust showed 100% staff attendance at mandatory training.
- Patients received evidenced based care and treatment and patients experienced excellent outcomes. There was participation in both local and national audits and other monitoring activities such as a yearly peer review.
- Consent processes were robust and documentation associated with these processes was adapted to the individual patient's needs and understanding.
- Staff provided caring, compassionate and respectful care. They were positive about working in the service. Medical staffing levels and skill mix were adequate for the service. Nurse staffing levels were as planned or above planned levels across the service and there was on-going recruitment.
- Patients and their families were continually positive about the care and treatment they received at the Harefield hospital. They told us they felt involved in their care and built strong, caring and supportive relationships with staff.
- There was a strong emphasis on multidisciplinary team (MDT) working. There were ward based transplant MDT meetings four times a week (Mon/Tues/Wed/Fri) with a larger Transplant MDT meeting for new patient assessments and on-going patient status presentations on the Thursday morning. There were other regular meetings in other surgical areas helping to ensure patients had a holistic care plan in place. Good MDT working existed between the trust and local hospitals with agreements for service provision as necessary including vascular surgery and dermatology.

- Service planning and delivery considered patients' needs, which meant changes to the service and its delivery benefited the patient. Support was in place for those patients and their families who had learning disabilities or were living with dementia.
- The surgical directorate had a clear leadership structure in place. Although we saw areas of good practice it was highlighted that senior management had no clear plan of how to improve on poor areas of care noted on the trust wide risk register. This included compliance with the WHO surgery checklist and managing deteriorating patients with a national early warning score observation system.
- There were many examples of staff and patient engagement in service improvement including innovations within the theatre patient reception area to provide a calm environment and reduce anxiety. Staff and patients alike were proud to be a part of the Harefield Hospital.

However:

- Although systems were in place to ensure incidents were reported, investigated and lessons learnt, follow up of incidents within the trusts 10-day period was poor. Incident management was in line with the duty of candour.
- Although staff provided care in line with NICE guidelines CG50 and the service had protocols and guidelines in place to assess and monitor patient risk, staff did not always complete patient observations charts correctly, which may put patients at risk of deteriorating without staff escalating this to the medical team.
- The trust provided information which demonstrated the delivery of the sepsis six bundle was included in their safety improvement plan for 2015-2018 and NEWS observation charts had been redeveloped to include relevant elements. However, band five nurses that we spoke to on inspection did not have an understanding of the 'Sepsis Six' pathway. Practice educators confirmed that this was not taught as part of any training given to nurses by the trust.
- Senior medical staff did not fully complete five steps to safer surgery checklist including the World Health Organisation (WHO) checklist despite several discussions about the risk to patient safety. The five

Surgery

steps to safer surgery checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of surgical procedures.

- The referral to treatment (RTT) national indicator trust performance fell below both the England average and referral to treatment standard of 92%. The 18-week RTT times for elective cardiac surgery were an issue due to an increased demand in the service. The trust explained they aimed to be back to standard by 2017.
- Cancellation rates of elective patient's trustwide had a marked increase in the first three quarters of 2015 to 2016 and this did not show signs of improvement. Most patients were rebooked for treatment within 28 days of cancellation.
- Staff had concerns over the ability to manage the number of referred patients in the physical space they had within the wards. Senior members of staff were trying to find ways to expand the space they had by looking at currently unused parts of the hospital.
- Some staff had concerns that senior medical staff would not always take into account their ideas even if it meant service improvement

Are surgery services safe?

Requires improvement



We rated safe as requires improvement because:

- There was poor completion of the five steps to safer surgery checklist despite staff discussions about patient safety risks with senior medical staff. An audit of the five steps in theatres showed that only 39% of the cases checked had a full five-step checklist completed.
- Staff did not always complete national early warning scores (NEWS) meaning some patients may not have been escalated to the doctors for review and managers could not tell us if they had been escalated. NEWS charts are patient observation charts that use observations such as heart rate, blood pressure and respiration rate. They allow staff to quickly determine if their patient is unwell or deteriorating depending on the score assigned to the observations taken.
- Although incident-reporting systems were in place and feedback was provided to staff to aid learning and prevent reoccurrence, incident reports were not regularly completed within the 10-day target set out by the trust. Although, the trust explained some investigations took longer than 10-days due to complexity.
- The trust had a safety improvement plan (SIP) updated in March 2016. This included areas for improvement such as reducing acute kidney injury in patients, reducing sepsis and improving detection and management of the deteriorating patient. We found that there were some poor areas of practice around these improvements.

However:

- Medicines were stored and administered safely.
- The wards and theatres were clean and well maintained. There were good Infection Prevention and Control (IPC) practices.
- Nurse staffing was suitable to meet the needs of patients. Highly trained medical staff provided regular patient reviews although the frequency of Consultant review was different across different wards.
- There was a comprehensive major incident policy, which staff practiced regularly.

Incidents

Surgery

- Staff knew how to report incidents. Staff told us that the trust on-line incident reporting system was easy to access. Managers circulated wider learning from incidents via a monthly newsletter and ward meetings.
- The total number of incidents recorded for surgery at the Harefield hospital was 1,324 from March 2015 to April 2016.
- There were two serious incidents (SI) reported for Harefield Hospital surgical services in the twelve months before our inspection. An SI is an incident that causes permanent or severe harm to a patient, staff, visitors or members of the public. The SIs reported were both within the heart division. Information received from the trust showed lessons learnt from these included a review of certain equipment such as a drain used for wound management post-surgery. We saw the surgical working group minutes from May 2016, which indicated one of these incidents was discussed, and actions to provide more medical device training for staff were to be put into place.
- SI reports we looked at included a detailed time line of events and a root cause analysis of the incident. Senior staff explained that formal root cause analysis training was not provided but they had good support from their clinical risk lead and senior managers.
- Staff knew how to use the online incident reporting system and felt confident in reporting incidents and near misses. Staff provided examples of incidents they had reported and the learning from these. We saw that Maple and Rowan Ward were in the top ten wards in the trust for reporting incidents in May 2016.
- Trust policy required all incidents be reviewed within 10 working days. The incident report review for May 2016 showed there were 55 incidents where the review was overdue within the heart division and six overdue in the lung division. Senior staff said there was often an on-going investigation meaning they could not close the incident report within the 10-day period.
- Staff received regular feedback on learning from incidents through monthly ward meetings and newsletters. Senior staff organised ward meetings across surgical departments to discuss incidents but attendance was often poor due to patient dependency. The newsletter meant all staff were aware of incidents if they could not attend the meeting.
- We saw posters in the staff room on Maple ward to communicate recent incidents. They showed the incident, actions taken, the possible lasting impacts and further potential risks to patients and staff. Incident report monthly updates were available on staff notice boards to demonstrate themes in incident reporting. The monthly update for April 2016 showed that theatres were one of the top 10 locations for reporting within the trust.
- Staff discussed incident reports and learning from these at the monthly matrons meeting and a monthly cross-site sisters meeting. The trust did not provide minutes of these meetings.
- Following an audit on Cherry Tree ward, the senior sister found staff did not feel confident in how or when to report incidents. The practice facilitator and senior sister carried out training around incident reporting. They were planning to complete a re-audit before the end of July to assess staff learning.
- The transplant unit had some of the highest rates of falls in the trust. Due to the figures, senior staff introduced intentional rounding in June 2015. Intentional rounding is hourly to two hourly patient checks completed and signed for by nurses. Within three months the falls rate had fallen by 83%. We saw that this number had remained low through data collected for the safety thermometer audit. In theatres, a health and safety board displayed incident trends including current learning from these. Staff identified situations requiring completion of an incident form and they told us there was a good reporting culture. The trust encouraged to report 'near miss' events in addition to incidents that had occurred. A near miss is an unplanned event that did not result in injury, illness, or damage but had the potential to do so.
- We saw notes from the mortality and morbidity meeting in January 2016. During our unannounced visit we attended a Consultant led morbidity and mortality meeting which was part of the monthly hospital governance day. They discussed patients who had died, the cause of death and what learning had come from the care the patient received. Junior doctors on the surgical wards told us they were invited to take part in monthly morbidity and mortality meetings. Transplant junior doctors also regularly attended the meeting and the transplant specific mortality meeting.
- Senior and junior staff understood the duty of candour. The duty of candour sets out some specific requirements that NHS providers must follow when things go wrong with care and treatment. This includes informing people about the incident, providing

Surgery

reasonable support, providing truthful information and an apology when things go wrong. One junior member of staff discussed an example of this following a drug error. Senior nurses discussed that duty of candour was now a part of incident reporting and investigation.

Safety thermometer

- Surgical wards had comprehensive safety thermometer data visible to staff and patients on arrival to the ward. Senior staff conducted monthly audits of patient falls, pressure ulcers and catheter related urinary tract infections (UTIs). The audits showed that patients received predominantly 'harm free' care. The NHS safety thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as falls, new pressure ulcers, catheter and urinary tract infections and venous thromboembolism (blood clots in veins).
- We saw that in May 2016, Rowan and Cedar Ward had posters indicating there were no pressure sores, falls or hospital associated infections reported.
- There were consistently low numbers of falls, catheter associated infections and pressure sores across the surgical directorate for the previous 12 months before inspection.
- The tissue viability link nurse was available to ensure staff carried out pressure area care and investigate incidents of pressure sores. Staff would complete incident reports and photographs for any pressure sore to ensure correct pressure ulcer grading and determine if healing was occurring.
- Staff followed National Institute of Health and Care Excellence (NICE) clinical risk assessment guidelines. Venous Thromboembolism (VTE) risk assessments were generally well completed. All patients, on admission, received an assessment of VTE and bleeding risk. VTE is a national tool used to reduce the risk of venous thromboembolism (deep vein thrombosis and pulmonary embolism in patients admitted to hospital). Of eight records checked, only one had not had a VTE assessment done.

Cleanliness, infection control and hygiene

- We observed excellent infection prevention and control (IPC) practices within the surgical wards and in theatres. The hospital had previously had a number of wound and surgical site infections. Actions were in place to reduce the number of these infections.

- Ten deep space surgical site infections (SSIs) were reported for coronary artery bypass graft, (CABG) surgery patients from February 2015 to January 2016. General cardiac surgery reported three SSIs in the same period. This was lower than the Public Health England (PHE) national benchmark of 4% for CABG and 1.2% for general cardiac surgery. CABG is a type of surgery that improves blood flow to the heart. A surgical site infection is an infection that occurs after surgery in the part of the body where the surgery took place. In January and February 2016, there were no incidents of any surgical site infections reported for cardiac surgery. We saw several areas of changed practice including a photograph on discharge and a hospital designed cardiac support bra to reduce SSI numbers.
- There were 20 surgical site infections in drive lines of ventricular assist device (VAD) patients between 2009 and 2015 out of 169 patients in total. A VAD is a mechanical pump used to support heart function and blood flow in people who have weakened hearts. Staff implemented a 10 point plan to make dressing procedures safer and included asked patients to refrain from showering as this was causing bacteria to grow in the wound.
- There were IPC link nurses and staff told us they attended IPC meetings and had infection control champions. These champions carried out IPC audits and could teach staff new areas of practice or policy.
- IPC link nurses carried out hand hygiene audits and these were visible on the wards. In May 2016, Maple ward had 65% compliance and Cedar had 91%. Rowan ward had 98% compliance. The trust target was 90% compliance and above. There was a compliance target of 100% for bare below the elbows, which was between 97% and 100% across surgical services.
- Whilst on inspection we observed that staff followed the "Hand Hygiene Policy" (March 2016) and were bare below the elbows during our inspection.
- Areas within the surgical directorate were clean, uncluttered and well maintained.
- Equipment we checked was clean and "I am clean" stickers were in place and in date. Staff in theatres told us IPC was a priority and gave examples where nursing staff had challenged surgeons to re-scrub to ensure adherence to safety procedures. They told us of recent

Surgery

changes to the way patient monitoring equipment was cleaned so that each staff member took ownership of ensuring the equipment was cleaned at the end of each shift.

- During our inspection, there was a possible infection outbreak on Cedar Ward. There was an IPC matron available and we observed staff using correct IPC techniques. The matron was able to give a clear plan for the outbreak and staff were using cohort nursing to reduce risk of spread.
- There were no incidents of MRSA or C-Difficile throughout the surgical areas in the last year. All patients had MRSA swabs completed before or on discharge and there were provisions to ensure infected patients were barrier nursed.
- The day care unit assessed patient's notes 24-48 hours in advance of their admission to assess infection risks. A side room was available for patients requiring source isolation. The room was shared overnight with the transplant unit to accommodate sleep study patients. However, senior staff told us they would have to cancel patients if the side room was not available during the day due to transplant patients requiring the room. This lack of space was on the risk register.
- Those patients who had confirmed infections had signage in place and staff used appropriate protective equipment before entering patient's rooms. Transplant patients who were immunosuppressed had specialist equipment for staff to use including facemasks, goggles and full-sleeved gowns. This meant staff protected those patients from any outside infection.
- We spoke to domestic staff who used coloured coded equipment for cleaning different areas. There were terminal cleans for specific infections such as MRSA, C-difficile and carbapenem resistant enterobacteriaceae (CRE) where a specialist "Bioquel" clean was used. CRE is an antibiotic resistant strain of bacteria. Each discharged patient had his or her room deep cleaned to ensure no spread of infection.
- Staff followed the trust's policy and procedures on CRE screening. National guidance outlines early detection, management and infection control of (CRE). Staff told us they were aware of a specific policy around "CRE" screening and we viewed this pre inspection.
- In theatres, a new dress policy was in place to prevent the spread of infection. Staff working in theatres wore

distinctive raspberry coloured scrubs; different from the blue used elsewhere within the hospital. Theatre staff would change into blue scrubs if they left and went to other areas of the hospital.

- A joint theatre cleaning audit took place weekly by the ISS cleaning supervisor and health and safety lead for theatres. The trust set the standard for these as 99% and results displayed demonstrated continuous compliance.

Environment and equipment

- All of the equipment we examined such as beds, commodes and observation trolleys were visibly clean. We observed green 'I am clean' labels were in use to indicate the time and date of the last clean. We observed staff cleaning equipment with sterile wipes after use and cleaning beds.
- Resuscitation equipment was checked. The trolleys were clean and secure. We found an equipment trolley on Cedar ward containing sealed boxes that should have been checked on a daily basis but had only been checked on 12 days in the previous 2 months. This was a risk to patient safety in case of an emergency the drugs had been missing or unusable and was highlighted to the ward manager.
- Wards and theatre areas we visited were clean and uncluttered.
- We checked a range of equipment in both theatres and ward areas. All equipment we checked was clean and stored appropriately. There was evidence that safety testing was completed.
- The transplant wards were locked and there was swipe card or telecom access only. Maple and cedar wards were open and were a public thoroughfare to other areas such as pre-assessment clinics. When asked if this posed a problem to patients and staff told us there was no indication of any safety issues. Following inspection we were told by senior staff that additional swipe access security doors had been installed.
- Staff completed medical equipment checklists, which a practice educator or someone specially trained in the use of that equipment, signed off. One junior nurse explained that there were ward champions for equipment such as patient controlled analgesia pumps. These champions provided training to ward staff and signed off equipment competencies.

Surgery

- We saw difficult airway equipment trollies available in theatres and the daily checklists completed with no omissions. Equipment we sampled was stored in the correct place, was clean and within date.
- In theatres, staff had safely covered floor wires with orange mat covers to prevent trips and falls.
- Single use equipment such as syringes, needles, oxygen masks and suction tubes were readily available and stored in an efficient manner in the anaesthetic and recovery rooms.

Medicines

- Medications were prescribed, stored and administered using hospital policy and guidelines.
- Medications were prescribed and administered via a password protected online system. Staff said this worked well but there were occasions where doctors changed prescriptions remotely but did not communicate this to nurses leading to drug errors. One nurse told us about a patient whose drug administration rate was changed remotely meaning the patient received the wrong amount of a drug. The patient was unharmed and an incident report was completed.
- Patients on the transplant unit could learn to self-administer their medications in line with the trust self-administration scheme. They had to sign a consent form stating they understood and were willing to take part in the programme. Safety Issues surrounding this self-administration of medication sat on the pharmacy and medicines management risk register. Issues included the patient taking the wrong dose of the drug or taking it at the wrong time. Such risks were reduced by ensuring that the measures described in the Trust policy were followed.
- Nurses completed a medicines competency including a written test before they could independently dispense medications. We saw staff adhered to the policy “Medicines Management Policy for the Prescribing, supply and administration of medicines” March 2016.
- Treatment rooms were clean and tidy in all areas we visited with cupboards locked and room temperatures within range. Daily fridge checks were well completed. There were daily controlled drug checks evidenced on Cedar and Maple Wards.
- The ward pharmacist we spoke to carried out daily medication checks and drug histories for new patients. They would check prescriptions were correct and provide support for both patients and staff surrounding medications.
- Emergency drugs were stored in a locked cupboard. Staff knew how to access emergency drugs when these had to be prescribed for patients.

Records

- We reviewed 15 sets of medical and nursing notes across four wards.
- Patient records were stored in a range of ways including integrated care pathways on paper for nursing and medical documentation. There were several online systems for test results. Nursing and medical notes were kept in ward offices, and patients notes were kept by their bedside. Staff told us it was frustrating that the different systems could not share information with each other such as test results and specialist nurse notes.
- Notes included evidence of risk assessments such as SSKIN bundles to assess the risk of pressure sores, falls and malnutrition universal screening tool (MUST). These were generally well completed.
- There were comprehensive pre-operative assessments using integrated care pathways for cardiac surgery patients, thoracic enhanced recovery patients and cardiothoracic transplant patients. We checked two pre-operative checklists that were fully completed ensuring all pre-operative safety checks for the patient were correct.
- All staff in theatres used an electronic critical care and anaesthetic information system to record patient and treatment information.

Safeguarding

- Staff were trained in safeguarding for adults and children and could give examples of safeguarding referrals they had completed.
- The trust had a policy in place to safeguard vulnerable adults and children. This was readily available to staff on the intranet. It followed guidelines from The Care Act 2014 and the British Medical Association Adult Safeguarding Toolkit.

Surgery

- Safeguarding is a part of mandatory training for staff and covers safeguarding adults and children. The trust has a target of 75% completion for this training and 100% of staff had undergone safeguarding training for both adults and children in the last year.
- Staff raised safeguarding concerns using the incident reporting system. Staff explained the process of recording and notifying the relevant teams about any safeguarding concerns. Some staff gave examples of safeguarding referrals they had previously completed.
- The hospital had a safeguarding lead and staff we spoke to were able to name them. A new safeguarding ambassador's role helped ward staff with complex safeguarding issues and difficult referrals.
- "Staff Guide to safeguarding adults at risk and people with learning difficulties" was a leaflet available on the ward for staff to use. This included types of abuse and what to do if there was suspected abuse.
- The Mental Health and Safeguarding Adults Committee 21st January 2016 meeting minutes were provided pre inspection. Issues surrounding delirium, policy changes, and prevent training were discussed. A delirium policy was not available to us at the time of inspection.

Mandatory training

- The overall mandatory training compliance rate for surgery services at Harefield hospital was 100% for all required topics including safeguarding, basic life support and information governance.
- We saw a Mandatory training and Induction Policy (2014). This set out the required frequency of training and duties of staff to ensure their training was completed.
- Staff accessed their training records and booked onto training courses via the online learning management system. The trust provided role specific mandatory training in areas such as fire safety and medical gases. Staff told us that they had benefited from the training and were more confident in performing their duties.
- Practice educators and facilitators on the wards helped ensure all staff had been booked on and completed their mandatory training. Staff were given protected time to carry out training.

Assessing and responding to patient risk

- The wards had some poor recording of observations and the steps to safer surgery checklist was not utilised as per guidelines. The WHO five steps to safer surgery

checklist is a simple tool designed to improve the safety of surgical procedures by bringing together the whole operating team to perform key safety checks during vital phases of perioperative care.

- In theatres, we saw the WHO five steps to safer surgery checklist tool in use. During discussions with staff, we were told most surgeons did not attend the team brief and that the sign out process was not always formalised. Staff told us it had been difficult to engage some senior surgeons in the checklist process. Staff told us it was now mandatory for surgeons to be present during the time out stage of the checklist and that this had been negotiated to agree that they did not have to be present during the team brief. However, the risk register stated that this was a mandatory part of the checklist and senior medical staff should be present.
- An audit of the five steps to safer surgery checklist in theatres in June 2016 assessed notes completed on the ward, before induction of anaesthesia, before skin incision, before the patient left theatre and on arrival to ICU. It showed that only 39% of the 28 cases checked had a full five-step checklist completed. The area most poorly completed was section five – handover to the ICU staff however the majority of cases had four out of five steps completed. Medical staff gave a presentation of findings at the Governance Day in June. On-going audits are to be completed and the trust told us they were working towards compliance with the full five steps.
- Sign in was carried out by the anaesthetic practitioners and we observed check in procedures including patient identity checks, checking that the surgical site was marked, allergy status and understanding of the operation.
- The trust had a safety improvement plan (SIP) updated in March 2016. This included areas for improvement such as reducing acute kidney injury in patients, reducing sepsis and improving detection and management of the deteriorating patient. We found that there were some poor areas of practice around these improvements.
- All surgical wards used the "National Early Warning Score" system (NEWS). NEWS is a simple scoring system in which a score is allocated to physiological measurements. It can indicate a deteriorating patient by an increase in the overall NEWS score.
- We reviewed four charts on maple and cedar ward and two had errors in addition of the final score in the days before our inspection. There was no evidence that these

Surgery

patients were re-assessed as per the protocol for a patient with high NEWS. There was no documentation that the patient was escalated to the team for review. When we asked staff if the medical team had seen the patient but they could not tell us if they had. We asked the nurse in charge to ensure the patients were safe. However, audits completed on NEWS charts in both May and June 2016 showed that between 75% to 100% of patients had correctly completed charts.

- Staff described to us the way in which patients with high NEWS scores were escalated to receive a medical review which was dependent on the score calculated from the patient observations. On the transplant ward, we did see evidence of correct escalation procedures documented in the patients notes.
- The trust provided information which demonstrated the delivery of the sepsis six bundle was included in their safety improvement plan for 2015-2018 and NEWS observation charts had been redeveloped to include relevant elements. However, band five nurses that we spoke to on inspection did not have an understanding of the 'Sepsis Six' pathway. Practice educators confirmed that this was not taught as part of any training given to nurses by the trust.
- Staff could identify patients at risk of acute kidney injury (AKI) on the integrated care pathway. The trust wanted to reduce the incidence of avoidable new onset AKI by 50% by 2018. An audit carried out in 2013 had shown that 92 thoracic surgery patients had been referred the critical care outreach team due to AKI. An intervention was implemented using hydration pre surgery and a re-audit in 2014 showed the prevalence of AKI decreased by 57.6%. However, there was poor AKI documentation completed throughout the wards. Staff explained that a patient with an AKI (Level 1-3) would be flagged up by the biochemistry team and clinical teams informed immediately.
- The transplant unit had devised a patient acuity tool called the "Nursing Workload Score" The acuity tool was based on the Critical Care Minimum Data Set that follows the approach of allocating levels of care to patients according to their clinical needs. Staff could assess the acuity of the ward by looking at the patient board and allocate or request staff accordingly to ensure patients were safe.

- Nurse staffing across all the wards was above the planned level determined by the trust, however, there were issues around hours of working for some theatre staff.
- Although the hospital had taken Friday off the weekend on call rota. Staff we spoke with voiced concerns about the on-call rota for the organ retrieval service. Staff gave examples of situations where they had worked excessively long hours. For example, after a full day's work they could be sent to retrieve an organ from anywhere in the country. One nurse told us once the organ had been retrieved staff would then also have to support during the operation. One staff member of staff told us of an example where they had worked 38 hours shift.
- Staff told us they had written letters of concern about these working hours however had not had a response from senior team leaders regarding this. Following inspection we were given written evidence that management had offered staff a change to opt out of retrieval service on call and some staff had accepted this offer.
- Surgical staff who worked after 12pm would get the hours back the next day. For example during inspection we saw staff allocated to "sleeping" and senior staff told us these staff would come in after their rest period if they were due to work the next day.
- The trust provided a nurse staffing indicator template for February 2016. This showed that across the surgical wards there was a ward fill rate of between 87% and 170% for day shift. Night shifts were over 100% fill rate on all wards. Reasons for high fill rates included an increased patient dependency.
- Staffing in theatres had improved with recent recruitment. At the time of inspection, there were no nurse vacancies in the theatre department as there had been successful recruitment of permanent nursing staff.
- Healthcare assistant support was available on each shift. Care staffing was less than 100% fill rate on days but between 98-112% on night shifts due to patient dependency.
- The "Nurse Workload Acuity Tool" allowed the transplant unit to employ extra staff on a shift if the acuity was high. This tool is a simple way of assessing the safe number of nurses needed for a ward to care for patients. There was no regular use of a staffing acuity tool on the surgical wards Maple, Cedar or the day surgery unit. When we asked senior staff how they knew

Nursing staffing

Surgery

they had sufficient staff they told us they would assess acuity themselves and request more staff if required.

The Royal College of Nursing (RCN) best practice principles do include the use of a workforce planning tool to support an effective approach to determining and reviewing staffing levels for patient safety.

- Ward sisters and matrons stated that there was normally one nurse to four patients on the surgical wards, which was adequate for the acuity of the patients within the surgical units. The wards displayed nurse-staffing levels as planned versus actual and during our announced and unannounced inspection the wards were fully staffed.
- Out of hours, on-call teams provided staffing in theatres, with the exception of the Night shift Anaesthetic Practitioner that supports intubated patients in catheter labs, amongst other roles. All teams are within half an hour of the hospital, and on call rooms are available for those who are not.
- Vacancy rates were low across the wards as per information provided by the trust prior to our inspection. A new band seven ward manager was waiting to start employment on Cedar ward. Newly qualified and newly employed staff were identified as risk within the ward risk registers as the numbers of new staff could affect the skill mix.
- Agency and bank staff regularly worked across Maple, Cedar and the transplant wards and we viewed an induction checklist. Packs included an orientation checklist and information on key policies. Healthcare assistants had to read a list of bullet points about caring for a patient requiring one to one care and sign to say they understood their responsibilities.

Surgical staffing

- The Health and Social Care Information Centre (HSCIC) data from September 2004 to September 2014 indicated the staffing skill mix was notably different to the England average. This was due to the specialist nature of the patients.
- There were 38% consultants compared to 41% England average. However, the National Cardiac Benchmarking Collaborative (NCBC) showed that there were 30 cardiothoracic surgeons registered which is greater than the England average. They had 60% registrar group where the England average is 37%. There was a low number of middle career and junior doctors at 1%.

- We saw clear on call rotas for both transplant and surgical wards. A registrar, SHO and Consultant provided cover 24 hours a day on all wards. Nursing staff we spoke with said consultants were available outside normal working hours and contacted by telephone for advice and support. They confirmed that surgeons would return to re-assess their patient if there were concerns.
- We saw the junior doctors' rota for surgical wards and clinics, which covered all shifts. The rota included the cardiac and thoracic advanced nurse practitioners.
- Surgical staff told us there was no formalised handover from shift to shift on Maple and Cedar wards however if there were any patient issues this would be communicated to the doctor taking over the shift.
- Consultants saw transplant patient daily and we saw evidence of this of the ward round and in patients' notes. Pre ward round the transplant consultant would do a full board round daily with the nurse in charge to discuss any surgical issues such as wound infections or unwell patients.
- Surgical staff told us there were cardiac consultant- led ward rounds on Monday, Wednesday and Thursday. Thoracic surgeons would see their patients daily but not at a formalised time. They would write care changes in the notes which we saw evidence of on inspection.
- Data we looked at showed locum use was high for surgical staff and anaesthetics compared to other directorates. Locum staff we spoke to had inductions, which included time with consultants prior to commencing employment to discuss policies and procedures. Following inspection the hospital told us that the locums were or had recently been employed by the trust in junior doctor positions.

Major incident awareness and training

- Staff knew about the trust major incident policy that was comprehensive and practised regularly. Staff we spoke with knew where to find local guidance and procedures to follow in the event of a major incident.
- Copies of the Major Incident and Emergency Response Plan were available on the wards along the appropriate Action Cards. Some nursing staff received major incident training and knew how to develop contingency plans for a major incident.

Surgery

- We saw a specific evacuation policy for each type of patient on the transplant unit, listing the essential equipment that each patient would need in the event of an emergency.
- During our unannounced inspection, the hospital carried out a training simulation to test their emergency response in a joint exercise with the Fire and Rescue Service and local hospitals. An emergency evacuation of the theatre recovery room, and casualty retrieval from the hospital's service tunnel was undertaken. They had similar exercises every 6 months.
- The on call executive and the on call manager carried the major incident and emergency response plan at all times.
- In the event of a major incident, there was a memorandum of understanding with Hillingdon Hospital to assist with taking patients. A memorandum of understanding (MoU) is a formal agreement between two or more parties to agree an intended line of action.
- Highly qualified staff had the specialist skills they needed to carry out their roles effectively and in line with best practice. The service identified the learning needs of staff and had robust training programmes to meet them. Managers supported staff to maintain and further develop their professional skills and experience.
- Managers supported staff with meaningful and timely supervision and appraisal. The service supported medical and nursing staff through the process of revalidation (confirmation by professional bodies that staff are up to date with their skills and continue to be fit to practice in the UK).
- Patients received care from a large multidisciplinary team (surgeons, anaesthetists, doctors, nurses and other staff working together) and this was well coordinated. All relevant staff, teams and services were involved in assessing, planning and delivering people's care and treatment.
- Staff could access the information they needed to assess, plan and deliver care to people in a timely way but there were problems with the communication between different online systems. Information sharing between the systems was not always timely, for example, test results were not available throughout the systems. Patients understood and had a copy of the information shared about them.
- Staff obtained patients' consent to care and treatment in line with legislation and guidance, including the Mental Capacity Act 2005. Patients were supported to make decisions and, where appropriate, their capacity to make decisions was assessed and recorded. Patients' freedoms were limited only when in their best interests and in line with the deprivation of liberty safeguards provided by the Mental Capacity Act 2005.

Are surgery services effective?

Outstanding



We rated the effectiveness of the service as Outstanding because:

- Patients undergoing surgery at the Harefield hospital had excellent outcomes for cardiac, thoracic and cardiothoracic transplant (heart, lung and heart-lung transplant).
- The service routinely collected and monitored information about patient care, treatment and their outcomes and used the findings to improve care. Outcomes for people who use services were better than the national average in many cases and excellent for cardiothoracic transplantation.
- The service planned and provided care and treatment in line with current evidence-based guidance and best practice.
- The service participated in relevant local and national audits, including a peer review within the transplant service. Audits were used to improve care and patients' outcomes not just within the hospital but in centres around the UK.
- Staff assessed patients' in a holistic manner. Senior staff reviewed and updated treatment regularly.

Evidence-based care and treatment

- The service contributed to the 'National Cardiac Benchmarking Collaborative' (NCBC) and the development of national standards. The NCBC is a UK-wide group of NHS specialist cardiac centres. It aims to improve the quality, efficiency and effectiveness of cardiac services through regular benchmarking and comparison of cardiac services. It identifies and shares learning from best practice to promote safe and evidence based care.
- The service provided care in line with National Institute of Health and Care Excellence (NICE) Guideline - CG50 - that covers recognising and responding to deteriorating

Surgery

patients. Staff used a national early warning score (NEWS) to identify deteriorating patients. Nurses across the surgical wards confidently discussed the escalation framework and were aware of the parameters that required referral to the medical team.

- The pre-assessment service followed NICE, Association of Anaesthetists of Great Britain and Ireland (AAGBI) and local guidelines to ensure appropriate pre-assessment of all patients prior to operations. Patients at risk of surgical complications were highlighted and the risks to health were reduced pre operatively. This helped to keep patients safe during surgery.
- We saw a strong commitment to clinical audit. In the transplant service, a weekly review of donor audits and morbidity and mortality cases were part of the multidisciplinary team meeting which we saw minutes for. A monthly transplant executive group reviewed the NHS Blood and Transplant audit. This ensured shared learning from incidents and best practice.
- The Ventricular Assist Device team provided research published in a national transplant journal and the transplant team have contributed to NICE guidelines on heart transplantation, which we saw during our inspection.
- The transplant team underwent a peer review in 2015 where staff from other heart and lung specialist hospitals came to inspect the service. The report highly commended the work the team was doing. It highlighted the fact that there was variable surgical practice and that the unit was fast reaching capacity. When we asked senior staff what was in place to rectify these concerns they told us they were trying different avenues to increase the number of beds within the unit. This included using beds in other hospitals and converting unused hospital space into wards.
- Policies and treatment guidelines were available online via the trust intranet. Samples of policies and guidelines we looked at referenced appropriate guidelines from bodies including The Joint British Diabetes Society and NICE. The pain team policies and procedures used guidelines including faculty of pain medicine, Royal College of Anaesthetists (2010) and The National Patient Safety Agency (2007).
- We saw frequent evidence of local audit activity displayed across all the surgical wards notice boards. On Cedar ward, staff teaching about the importance of good documentation was put in place to following evidence of poor practice such as poorly completed risk

assessments. A surgical doctor told us a recent Venous Thromboembolism (DVT) audit had prompted a change in the prescription of VTE prevention on the electronic prescription system. Staff could not prescribe any medication until the VTE risk assessment was completed and the appropriate prevention prescribed. The VTE risk assessment assesses a patient's risk of developing deep vein thrombosis (clot). Medical staff can prescribe anti-clotting medications and specialist stockings to prevent this if the patient is at risk.

- The day care unit completed audits on waiting times for patients based on their operation in order to talk to consultants about inappropriate waiting times. They were auditing the length of time staff were taking dealing with pharmacy-related issues on the unit. The senior sister told us the audit was helping to build a business case for a part-time or full-time pharmacist on the unit.
- Regular audits took place in theatres including hand hygiene, skin preparation for surgery, endoscopy use and pre and post-operative pressure area care. Staff would discuss any problems with results at their staff meetings or the trust Governance day. Meeting minutes were available for us to look at pre-inspection. Learning could be shared within these meetings and changes implemented.

Pain relief

- A nurse-led pain team provided a wide range of pain services across Harefield Hospital and The Royal Brompton Hospital. The pain team worked Monday to Friday 8am until 4pm on the Harefield site with a lead anaesthetist to support if required. Out of hours, the anaesthetic team on call provided cover to ensure all patients could have a pain review if required.
- The pain team had their own column on the nursing and surgical handover sheets to promote continuity of care concerning pain relief. We saw both nurses and doctors using this when handing over patient care.
- Pre-assessment nurses identified patients who might require post-operative pain management support and clinics were available for patients experiencing chronic pain related to their surgery. Patients with a VAD had specific clinics with the pain team due to the complex nature of the device and pain issues that arose.
- There was a range of leaflets for patients to take home including "Managing your pain at home after lung

Surgery

surgery” and “Managing your pain at home after cardiac surgery”. These included contact information for the team and how to reduce medication doses once discharged.

- The pain team provided study days for staff, which included pain physiology and psychology and the management of pain medication side effects. They taught staff how to use epidural and paravertebral block pain relief methods to ensure safe patient care. These are intravenous pain relief methods given via or around the spine. Staff on the ward stated that they had attended this training and found it very useful.
- The Pain team received an award at the Pain Awards 2015 for their work around pain management following device insertions such as implantable cardioverter defibrillator (ICD).

Nutrition and hydration

- Although staff told us there were many patient complaints about food choice and quality being poor the surgical directorate had tried to improve this.
- On all wards we saw a variety of food choices were available and snack boxes ordered for those patients who would miss a mealtime due to surgery.
- Dieticians were ward based and patient records we viewed included assessments of their nutritional status. These were re-assessed every Wednesday as a minimum to assess for any changes or deterioration. Dietary supplements were available on all the wards for those patients who required them.
- We observed accurate and up to date fluid balance charts and patients were administered intravenous fluids if necessary to prevent dehydration.
- Patients who needed enteral or parenteral feeding had pharmacy and dietician involvement and they ordered feed accordingly. Parenteral feeding is a type of feed given intravenously and enteral nutrition uses a tube inserted into the stomach or bowel to feed. Staff told us they had specific training to administer the feeds.
- The 2016- 2019 Nutrition strategy developed by the trust had seven standard statements. These included “Complex nutritional support, enteral and parenteral feeding, will be undertaken and monitored by appropriately skilled dieticians and multi-professional staff “ and “Nutrition screening and monitoring of all patients upon admission to hospital and throughout their hospital stay” both of which we saw during our inspection.

- Ward dieticians audited adherence to protected meal times in 2015. Protected mealtimes are periods on a hospital ward when all non-urgent clinical activity stops. Recommendations following the audit included nursing staff should be involved in delivery of meals and implementation of protected meals times from 12pm to 1pm on all wards. We saw both of these recommendations had been actioned throughout the wards with visible protected mealtime posters.
- Nursing staff documented patients’ nutritional needs on nutrition boards in ward kitchens. These showed patient specific dietary needs so housekeeping staff could provide specific food choices for patients. Staff identified patients who required assistance with eating and drinking using a red tray system. The red tray system alerts staff to those patients who need assistance with eating and drinking. We observed staff treated patients who required assistance with dignity and respect.

Patient outcomes

- Post-operative patient outcomes within the hospital were generally better than the England average. Post-operative patient outcomes within the hospital were generally better than the England average. However, average length of stay was higher than the national average.
- The “Annual report on Cardiothoracic Transplantation 2014/15” showed there were 186 adults on the active heart and lung transplant list on 31 March 2015. This was more than any other transplant centre in the UK. Staff said there was not always enough room to accommodate patients on the unit and they would have to be nursed on other surgical wards at times. If this happened transplant staff would go and assess the patient to ensure they were safe.
- The same report showed that lung transplant patients had the highest rates of survival in the UK from the time of being put on the transplant list and up to 10 years following this. They were below the national death rate for both single and double lung transplants. From April 2010 to March 2014 heart transplant patients had lower rates of survival than the national average at one, three and five years post-transplant. However they were in the top three trusts in the UK for survival from time of being put onto the heart donation register at one, five and 10 years.

Surgery

- The NHS Blood and Transfusion Service (NHSBT) Annual VAD report 2014/2015 showed that the hospital had the UK's second highest survival rate for patients with VADs from April 2012 to March 2015. The average length of stay for bi/lobectomy patients (removal of part of the lung) was 7 days (Sept 15). In general, the average length of stay was higher than the England average for both elective and non-elective surgery including cardiothoracic transplant. Elective cardiac surgery was lower than the 8.8-day national average at 8.6 days.
- The National Lung Cancer Audit 2014 showed the trust scored better than the national average for “% of patients receiving surgery all cases”. 69.6% of patients received surgery compared to the England and Wales average of 15.1%. However, the trust was more than 70% lower than the national average for “discussed at MDT”.
- The hospital contributed to the National Emergency Laparotomy Audit 2015. It showed the hospital was rated green (80-100%) for five of the ten measures audited. Two measures were rated yellow (50-69%) and the remaining three were rated as red (0-49%). The rating for final case ascertainment was unavailable.
- Data from Health Episode Statistics (HES) showed patient relative risk of re-admission rates for the Harefield hospital. It indicated they were higher than the England average for elective cardiac surgery and emergency thoracic surgery from August 2014 to July 2015. They were better than the England average for re-admission for both elective and emergency cardiothoracic transplantation.
- NICOR (National Institute for Cardiovascular Outcomes Research) produced a National Adult Cardiac Surgery Audit covers the period April 2011 – March 2014. It showed there was total of 2640 operations used in the data. This demonstrated they were below the national average for in hospital risk adjusted survival rate but still within the control range. The UK national average of survival was 97.70% and the Harefield scored 96.78% which remained within the control range. However, they operated on patients with greater risk factors for operative death than the national average.

Competent staff

- Practice educators provided significant support for nurses in helping them achieving key competencies.

There were differing levels of senior support and teaching for medical staff. Practice educators are senior nurses who provide teaching within the ward environment.

- Nurse practice educators were visible on each ward and in theatres. A practice facilitator was available for ambulatory care on Cherry Tree Ward. All nurses completed a competency booklet which a senior nurse approved once the nurse or healthcare assistant has proved their knowledge and skill in a certain area. This ensured no nurse or healthcare assistant worked outside their scope of practice.
- A newly qualified nurse told us they were completing a six-month preceptorship programme that included an intravenous drug administration day. Several new members of staff told us they felt well supported when starting work at the hospital.
- In theatres all new staff were assigned two mentors and had regular meetings with these mentors, alongside the Practice Educator to assess their progression and competence. One nursing student interviewed had been assigned two mentors and was rotating between anaesthetic and scrub areas during their theatre placement.
- Revalidation for nurses is a new scheme set up by the Nursing and Midwifery Council (NMC) to ensure that nurses and midwives are practising safely and effectively. Nursing staff we spoke to felt well supported in preparing for revalidation. We saw an education board with information about how to complete the revalidation portfolio on Maple ward. There were senior nurses in charge of revalidation across the wards. Staff attended teaching sessions and several nurses had successfully submitted their portfolios to the NMC.
- Senior nurses were leaders for an allocated team of junior staff and carried out their appraisals. Appraisals followed the trust values. Nursing appraisal rates within the theatre department were 82% and the theatre practice development nurse (PDN) was able to demonstrate gaps due to sickness, annual leave or maternity leave. They told us this figure had improved substantially within the last six months.
- Figures we received for Fir Tree Ward from April 15 to April 2016 showed that although 100% of nurses had an appraisal only 73% of HCAs had one completed. Staff we spoke to on the other wards said that they had had an appraisal in the last year and they found it helpful in setting out goals for progression.

Surgery

- Medical staff appraisal rates were variable across the surgical wards and anaesthetics. From March 2015 to March 2016, appraisals were between 50% and 86% complete. Staff we spoke to told us these were valuable and they felt they did direct their learning needs appropriately.
- Information received prior to inspection demonstrated 100% of medical staff had completed revalidation. Surgical staff told us that although there was no formal consultant teaching they had regular teaching on the ward. There was a weekly where they presented a patient's case for discussion to their peers. Staff said this was a valuable learning experience for more complex cases.
- Band 5 nurses could apply for an eighteen-month rotational post. These nurses rotated through three six-month placements including transplant, surgery and critical care. On completion, the nurse gained a competency passport and had a guaranteed job within the surgical directorate. One staff member told us they had gained valuable experience from this programme and felt they had skills they would not have obtained from a regular nursing post.
- Band 6 nurses in theatre told us they had access to the enhancing leadership and performance program. This allowed them to progress and improve their leadership within healthcare. On each of the surgical wards, there was support for band five nurses who wished to progress to band six. We viewed completed competency booklets for some staff who were applying for a band six position.
- Several nurses told us they had been on further training such as cannulation and venepuncture (taking a blood test), acute respiratory and cardiac care courses to further their learning. A healthcare assistant was starting their nurse training in September supported by the hospital. Staff felt that accessing courses was simple and many had gained a wealth of skills such as being able to work in the high dependency unit.
- Each ward had nurse "champions" who were specialists in certain areas including infection control and discharge planning. They taught other members of staff specialist skills and attended meetings with other champions in the hospital. We saw posters advertising group meetings to discuss learning and plans for the future of the roles.
- Transplant surgical staff told us they had formalised teaching once a week that was consultant led. A previous session had focussed on heart failure in transplant patients, which they said was very helpful in ensuring they were following best practice.
- Consultant specific outcome data was available from both the trust and NICOR (National Institute for Cardiovascular Outcomes Research). The lung division surgeons generally performed better than expected for risk assessed 12-month survival from April 2015 to September 2015. Data completeness of patient records for the same group from April 2015 to January 2016 was between 80% - 99.3%.
- The National Institute for Cardiovascular Outcomes Research (NICOR) dataset showed that generally cardiac consultants were within the safe limit for patient post-operative survival. Consultants routinely operated on patients who had greater risk factors for operative death than the national average and the rate of in-hospital survival post operatively was between 94.34% and 100% with the national average set at 97.7%.

Multidisciplinary working

- We observed good multidisciplinary team (MDT) working between medical, nursing and allied health professionals throughout our announced and unannounced inspection.
- Staff told us that on the Transplant unit there was an MDT meeting most weekdays with consultant attendance. During our unannounced inspection, we observed an MDT meeting on Rowan Ward. Staff discussed inpatients, waiting list patients and those awaiting transfer from other hospitals. Records we saw showed evidence of MDT discussions in both the transplant unit and Maple and Cedar Wards.
- Staff told us about strong MDT links between transplant doctors, co-ordinators and the transplant pre-assessment clinic. They involved psychology, palliative care nurses and the pain team amongst others to ensure patients received holistic care. Physiotherapists, social workers, dieticians and occupational therapists were visible during our visit.
- There was MDT involvement at the pre-assessment stage for cardiac and thoracic surgical patients if required. Staff told us a physiotherapist saw a patient

Surgery

pre operatively to ensure correct positioning on the operating table to avoid exacerbating a pain condition. They said this had worked well and the patient had well controlled pain post operatively.

- A physiotherapist we spoke to said they had specific teaching sessions with consultants. They had also attended joint governance and safety meetings with the team at the Royal Brompton Hospital to discuss learning from incidents. We saw minutes from these meetings prior to our inspection and the agenda included the appraisal review calendar, governance issues, and safety breaches.
- The complex discharge team told us they attended different MDT meetings on different surgical wards throughout the week. The meetings were their opportunity to assess discharge problems or safeguarding issues. They aimed to ensure patients were safe and highlight requirements for extra support on discharge. Early intervention in these matters meant that the risk of delayed discharge or re-admission for social reasons was low.
- Tissue viability nurses were available within the trust and were involved in incident reports and root cause analysis of pressure ulcers. Nurse handovers included tissue viability involvement to encourage healing from the earliest opportunity.
- The MDT had a comprehensive set of clinical guidelines and patient pathways. This included integrated care pathways that nurses could follow throughout the patient journey to encourage safe recovery as quickly as possible. As a specialist cardiothoracic hospital, there were well-established service level agreements in place for the on-site provision of other specialised services including vascular surgery, dermatology, endocrine and renal input for transplant patients.
- Transition services were set up for transplant patients. A senior sister held a clinic twice a year at a children's hospital which provided transplants for children and young people. Young people transitioning to the adult service visited the Harefield Transplant wards to meet the staff and make transition easier and less frightening.
- Consultants for transplant, heart and lung surgery were available 24 hours a day. On-call rotas for medical staff had appropriate cover with both junior and senior medical staff to ensure patient safety at all times. We saw rotas during our announced inspection.
- Staff told us the on-call transplant consultant had a consultation about all admissions out of hours and they completed weekend ward rounds. Patient notes did include consultant input during weekends.
- The VAD team provided a twenty-four hour service via a bleep, without of hours calls diverted to a mobile phone which patients could ring for advice. During our unannounced inspection, we saw this was utilised for a patient who was concerned about their dressings. Staff gave advice over the phone to prevent an admission.
- The transplant team provided a 24-hour bleep advice service for pre and post-operative patients who had concerns around their health. The nurse in charge of the transplant ward held the bleep out of hours and could facilitate and admission if required.
- Physiotherapists provided cover seven days a week. At weekends, staff saw priority patients. Physiotherapists were contactable by nursing or medical staff for emergencies overnight. A rehabilitation assistant worked on a Sunday as well as during weekdays. Staff said the assistant post was a developing role that allowed them to see a larger volume of patients.
- Pharmacy provided a Monday to Friday service. There was a ward pharmacist on a Saturday from 9am until 3pm. The transplant services had a clinical pharmacy service from 9am – 5.30pm Monday to Friday. There was a 24-hour on call pharmacy service for the whole hospital to cover emergencies.
- Staff told us that occupational therapist and discharge teams did not work weekends.
- Theatres were open for elective operations Monday to Saturday. At night and on Sundays an on-call team provided emergency and transplant services for sick patients.

Access to information

- There was access to information for patients both pre and post operatively. Nursing handovers were thorough however, doctors' handovers varied. Staff told us IT systems were complicated and did not always communicate important information between each system.

Seven-day services

- There was full medical cover seven days a week 24 hours a day. Some allied health professionals and pharmacy did not offer a seven-day service.

Surgery

- Staff provided cardiac, thoracic and cardiothoracic transplant patients with comprehensive pre-operative information. Thoracic patients who were on the enhanced recovery programme (ERP) received physio exercises and information regarding the programme before they came to clinic. The enhanced recovery programme aimed to improve patient outcomes and speed up a patient's recovery after surgery.
- ERP patients received a diary in the pre-assessment clinic that gave clear instructions about pre-operative preparation. It provided them with times to start fasting and information about medications they should and should not take. All patients received hibiscrub anti-bacterial wash to use pre-operatively to prevent infection.
- Transplant patients received several booklets of information pre and post operatively. They had comprehensive discharge information and had to sign a form to say they understood all the information. It discussed areas of care such as self-medication and diagnosis of organ rejection. The senior transplant nurse chaired the discussion and made the decision that the patients were competent and safe to care for themselves on discharge.
- During our unannounced inspection, we observed a nurse handover on Maple ward. This included discharge plans and post-operative complications. All nurses on shift were present for the handover to ensure continuity of care in case a nurse had to leave the ward.
- Staff told us there were sometimes difficulties accessing information as the different IT systems used in the trust did not always communicate. Sometimes care staff would write instructions on one system but this would not transfer onto other systems. When we asked how they would prevent missing care instructions or checking test results they told us "we just check all the systems" and they had not missed anything before. This may compromise patient safety if staff did miss care instructions.
- Pre-assessment clinic nurses told there was rarely an issue with obtaining patients' notes. The hospital shuttle bus could transfer notes from The Royal Brompton Hospital if necessary.
- In theatres, there was an electronic theatre list displayed in a central location. The paper master copies are available at the patients reception area and outside the theatre office. Theatre staff told us the co-ordinator would update this at regular intervals.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff understood the importance of consent to treatment and could explain in detail the steps they would take for patients who were unable to make decisions and consent themselves. Patients gave good feedback stating they felt able to ask questions about treatment during consent process. Consent forms we looked at were correctly completed.
- In theatres, we saw anaesthetists and anaesthetic staff checking patients understanding of procedures before taking the patient into the theatres and checking patients had signed their consent forms.
- Staff told us they had training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards (DOLS) as part of their mandatory training. We confirmed this by looking at the mandatory training records of staff.
- They were able to explain the steps they would take for those patients requiring a MCA and DOLS and explained there was support from doctors and the complex discharge team when completing the correct paperwork.
- We observed that a patient who did not have capacity to make decisions had thorough documentation on Maple ward. There was evidence of a mini-mental test (memory test) and psychologist assessments both pre and post-surgery. There were documented discussions with the patient's family and a DOLS was in place so the patient could have one to one nursing.

Are surgery services caring?

Outstanding



We rated caring as Outstanding because:

- Patients and their families were continually positive about the way staff treated them. Patients said the care they received exceeded their expectations.
- The culture focused on patient centred care which was visible during our inspection. Staff showed they were highly motivated and inspired to offer care that was kind and promoted dignity. Staff relationships with patients and those close to them were strong, caring and supportive.

Surgery

- Patients told us they were active partners in their care and felt fully involved in decisions around treatment. Staff empowered patients to have a voice. People's individual preferences and needs were always reflected in how care was delivered.
- People's emotional and social needs were highly valued by staff and were embedded in their care and treatment.

Compassionate care

- The Friends and Family Test (FFT) for the surgical wards was 98% from March 2015 to February 2016. This was higher than the national average of 96%.
- We spoke to 16 patients on the surgical wards and transplant unit during our inspection. All reported that the overall care that they received was excellent. The majority described the staff as sensitive and caring and one patient described that staff treated them as if they 'were an old friend'.
- The transplant unit had successfully introduced 'Sunshine Therapy' in-line with its 'Compassionate Care Programme'. This encouraged patients who spent most of their admission indoors to spend time outdoors to help improve their physical and mental well-being. Staff in theatres also told us about the "compassionate care programme" which encouraged staff to make improvements in patients' care. Staff on the program would meet once a month for six months and complete an improvement project at the end of the course
- Maintaining patients' privacy and dignity was paramount to staff and all patients we spoke to said they felt they were treated with respect. We saw evidence that nursing staff had a good rapport with their patients during a morning medication round.
- Two patients reported that the use of agency staff was affecting the hospital's high levels of care. One patient felt that they did not offer the same continuity of care as permanent staff. Another patient felt they were not as caring and attentive. An agency nurse left him without his preferred drink throughout the night and did not answer his call bell. He also reported staff only changed his dressing when he requested.

Understanding and involvement of patients and those close to them

- Patients told us they felt well informed about their care and treatment and any proposed changes. They said staff had good communication skills and explained things in way that was easy to understand.
- The transplant unit had regular communication with patients once discharged and patients felt well supported and able to call the unit for advice at any time. This involved a 24-hour bleep system for any concerns patients may have.
- One patient reported that staff broke bad news regarding their condition in a sensitive manner and they were fully involved in discussions around their treatment options.
- Families of patients felt included and well supported in the care of their relatives. One patient told us that the ward had arranged accommodation for his wife to avoid her having to travel a long distance to and from the hospital.
- One patient was too unwell to travel home for their birthday so the transplant unit set up a birthday party for them and their family in the day room.

Emotional support

- Patients had access to an on-site psychiatric nurse specialist who could facilitate a psychiatric doctor consultation and counselling services. All patients on the transplant unit had their requirements for counselling reviewed daily at MDT meetings.
- A 24-hour multi-faith chaplaincy service was available along with an onsite multi-faith prayer room.
- Clinical nurse specialists supported patients before, during and after treatment. They discussed patient's specific concerns about procedures and acted as a regular point of contact throughout the patient journey.
- Patients could receive visits from volunteers who had previously had surgeries to have peer support. The ward would facilitate this via a regular peer group on the ward run by a ward sister.
- One patient we spoke to told us the transplant unit arranged for a violinist to visit and on our visit we saw him playing to patients.
- Staff had access to counselling services to discuss any distressing situations they had encountered on the wards. One nurse told us they had used the service and found it very helpful.

Are surgery services responsive?

Surgery

Good



We rated the responsive as good because:

- Staff plan and delivered services in a way that met the needs of the local and wider population. The importance of flexibility, choice and continuity of care was reflected in a comprehensive pre-assessment clinic to 24-hour post-operative care via bleep systems on discharge.
- Care and treatment was coordinated with other providers including local hospitals who provided services within the Harefield Hospital such as dermatology and vascular surgery.
- There were low numbers of complaints throughout the service. Patients could complain or raise concerns and they were treated compassionately if they did. Staff dealt with complaints in an open and transparent manner. We saw improvements made to the quality of care because of complaints and concerns.

However:

- Cardiac surgery were consistently below the referral to treatment time 18-week Referral to Treatment (RTT) national indicator of 92%. However, the trust had a remedial action plan in place to meet the target in 2016/2017 including implementation of weekend surgical lists.
- Cancellation rates of elective patient's trust wide had a marked increase in the first three quarters of 2015 to 2016 and this did not show signs of improvement. 99% of patients were rebooked for treatment within 28 days of cancellation.
- Staff told us facilities and premises are not always appropriate for the services delivered due to the age and layout of the building. Staff told us there were insufficient beds on the transplant unit and this was on the risk register with plans such as the Gatehouse patient accommodation facility put in place.

Service planning and delivery to meet the needs of local people

- Harefield hospital surgical services were keen to demonstrate their national role in cardiothoracic

surgery. The hospital provided services to patients from the local area but was also a national referral centre for certain specialities. Data demonstrated that only 30% of their patients came from the London area.

- The transplant service provided care nationally. Twelve months ago, the unit opened a four-bedded unit called the "Gatehouse". This was for patients who were ready for discharge but wanted an extra night near the hospital before they went home or needed to stay overnight due to travel times. This was part of the risk register action plan to deal with the large demand for the transplant service.
- Following inspection the hospital provided evidence that an additional 20 bedded ward, 6 bedded intensive care unit extension were at an advanced stage and work due to be completed in 2017. This aimed to give the hospital more access to beds during high levels of demand for surgical services on the site.
- Thoracic surgery patients could stay in Parkwood house if they wished to stay overnight following or before their clinic appointment to reduce travel times and prevent an acute bed being used.

Access and flow

- Although the trust was not reaching its 18-week Referral to Treatment national indicator (RTT) the transplant team had the highest rate of retrieval of organs in the UK. The pre and post-operative clinics were thorough and aimed to accommodate patients' needs at every stage of their treatment.
- The trust was failing to reach the Referral to Treatment national indicator (RTT) target of 92% achieving 83.1%. However, in April 2016, cardiac surgery at the Harefield achieved 77.5% however thoracic surgery achieved 100%. The incomplete pathway standard is the measure of the patient's right to start treatment within 18 weeks. Senior leaders told us this was due to a steep increase in activity particularly in emergency work, which disrupts elective surgery lists and told us they hoped to reach the RTT target consistently by April 2017.
- The trust provided information detailing a remedial action plan to achieve the 92% target. It detailed issues including the complexity of the surgery meaning only one to two patients could be operated on per day and patients required significant level two or three care post

Surgery

operatively. We saw that the RTT target was on the risk register. We saw that the hospital had implemented weekend theatre lists to try to meet the 92% target effectively.

- Cancellation rates of elective patient's trust wide had a marked increase in the first three quarters of 2015 to 2016 and this did not show signs of improvement. 99% of patients were rebooked for treatment within 28 days of cancellation.
- The majority of surgical admissions were elective at 66% as the hospital was a tertiary referral centre. Thoracic surgery admissions were 45%, cardiac surgery 41% and cardiothoracic transplant 13%. 20% were day cases and 14% were emergency admissions. Theatre utilisation rates between November 15 and January 16 were 79.9% to 93%.
- Data provided by the National Organ Retrieval Service demonstrated from April 2014 to March 2015 that the Harefield retrieved 26% of all cardiothoracic organs in the UK, not only for the hospital but for other transplant centres. This was the highest retrieval rate, compared with any other centre. Senior members of the heart division told us there were always staff, theatre space and beds available for transplant operations to take place when organs became available.
- Senior cardiac clinicians saw cardiac surgery patients at their local hospital or a cardiac clinic at Harefield. There were pre-admission clinics for cardiac, cardiothoracic transplant and some thoracic surgery patients. Staff told us that patients had all the necessary tests they needed at one clinic including ECHO, blood tests and MRSA swabs. At the time of our inspection, the CT scanner was broken and was undergoing repair so staff recalled those patients if they required a CT scan.
- Bed management was co-ordinated differently in each area. The nurse in charge of the transplant wards dealt with cardiothoracic transplant admissions. High dependency or intensive care patients had priority for a ward bed. Staff considered the acuity of those patients in need of transfer from other hospitals during morning round. Surgical wards had a specific bed manager who co-ordinated surgical and day surgery admissions.
- There was a treat and return service for some cardiac day surgery patients at other hospitals in the area. Day surgery senior staff discussed their admission at a

morning meeting in the catheter labs. Patients attending under this service had an admission and discharge to their local hospital the same day to prevent further delay in their treatment.

- Estimated dates of discharge were up to date for patients on all wards and staff told us they would often involve the complex discharge team if a patient had a delayed discharge for non-medical reasons such as a social package of care.
- The complex discharge team could see patients pre-operatively if necessary. Staff knew how to refer to the team if they had concerns over a patient's discharge needs and complex social requirements such as a large package of care or issues that the patient was a vulnerable adult.
- A discharge lounge had been set up on Cedar ward in 2011 for surgical patients. There were four members of the team and a home care sister would go out to do home visits for patients if required. Staff cared for patients in the discharge lounge once they had medications ready and transport booked. Staff could complete district nursing and warfarin clinic appointment for patients so ward nurses could prepare for post-operative patients.

Meeting people's individual needs

- Patients' needs were at the forefront of care across the surgical areas. Patients had been involved in designing some of hospital features to make them more accessible for everyone using the hospital.
- Patients ready for theatre attended the theatre reception area and had their details checked. Before the patient was admitted into the anaesthetic room staff would ensure the theatre was prepared appropriately. Patients helped staff to design the admission area with relaxing dimmed lights and visual artwork on the wall to alleviate anxieties.
- On the wards there were side rooms for patients and single sex accommodation for those not in side rooms. The day care unit kept each bay single sex and there were single sex toilet and showering facilities.
- The transplant wards offered a 24-hour menu and staff offered patient's meal vouchers for the canteen if they wished to eat off the ward. Transplant patients had fridges in their rooms for their own food. Housekeeping staff checked these fridges daily to ensure food was in date and fridges clean.

Surgery

- Translation services were available over the telephone using language line and staff could tell us how they would use this. Information leaflets were available to order in several different languages including Arabic.
- Staff told us that they had several ways of communicating with patients on discharge including telephone calls and photographs to check wound dressings. Transplant patients could contact a 24-hour bleep if they felt unwell or had questions about their wound or devices.
- Staff told us there was link nurse for those patients with a learning disability but could not name them. They explained there were hospital passports available for patients with a learning disability to fill out with their families so staff could attend to their needs in a personalised way.
- We viewed the “Trust Dementia Strategy” which linked with the national dementia strategy. The national dementia strategy set out a vision for transforming dementia services with the aim of achieving high quality care from an early stage for patients living with dementia. The trust strategy included improving support for carers of people living with dementia and developing a skilled workforce.
- Staff received dementia training as part of their induction and were able to tell us about “This is Me” documentation and where it was kept. “This is me” is a document that people with dementia and their families fill out to tell staff their needs, preferences, like, dislikes and interests. It allows those who have difficulty communicating to have person-centred care.
- The trust had no way of identifying patients living with dementia on computer systems or within the notes. Staff told us their handovers included detailed information on patients living with dementia therefore this was not missed.
- Staff wore “Hello, my name is...” badges. This was a campaign started to ensure staff are introducing themselves and patients know who their named nurse is making care more personal.

Learning from complaints and concerns

- There were low numbers of complaints across the surgical directorate and staff told us how they would deal with these should they arise.
- Staff we spoke to across the surgical wards told us that there were very few complaints but the main complaints

they received surrounded food and waiting times. Senior staff told us they did try to make changes based on patients’ complaints. Main complaint themes were around food standards and noise.

- We saw comment cards where patients had documented things they felt could be improved. These were visible on the ward with ways in which staff had made changes to rectify these concerns. Areas of change included the introduction of quiet close bins as patients said the ward was very noisy at night.
- There was a complaints policy in place and staff knew how to access it. Staff understood how to manage complaints locally and who to refer to for resolution or escalation. Contact details for PALS (Patient advocate and liaison service) were clearly visible across the hospital.

Are surgery services well-led?

Good



We rated well-led as good because:

- The leadership, governance and culture within the Harefield surgical division aimed to improve the delivery of high quality person-centred care. The two trust sites carried out regular governance and performance management reviews.
- The trust, ward and nursing strategies were visible and achievable for staff.
- A systematic approach to working with other organisations aimed to improve care outcomes for patients including working with other specialities in other hospitals.
- Leaders had a visible and shared purpose. They aimed to deliver and motivate their staff to succeed. Comprehensive leadership strategies had continued to develop to empower staff to challenge poor practice.
- Staff were proud of the trust as a place to work and spoke highly of the culture. There were high levels of constructive engagement with staff and patients.
- The trust used innovative approaches to gather feedback from people who used services and comments and suggestions were actioned where possible.

Surgery

- The leadership drove continuous improvement and staff were accountable for delivering change. Staff and patient innovation was celebrated.

However:

- There were some concerns around senior clinicians acknowledging other staff members ideas and suggestions into account with regard to service change.
- There were concerns around poor risk management by senior managers in areas of care highlighted on the risk register including the five steps to safer surgery checklist and managing deteriorating patients. We also saw poor practice in recording patient observations and the sepsis six and senior staff could not tell us how this was being managed.

Leadership of service

- There was a committed leadership team for the surgery services within the heart division. Staff we spoke with told us their senior leaders were supportive and told us the nurse leadership of the surgical wards was excellent.
- A team of band seven practitioners supported the interim manager in theatres. All staff in theatres from consultants to nursing students were complimentary of the running of the department in the interim and told us they felt the management team was approachable and supportive.
- The cardiac and thoracic divisions were led by a divisional director, divisional general manager and divisional nurse manager. There were chairs for each disease group such as adult congenital heart disease and cancers.
- The surgical nursing structure included matrons, wards managers and staff told us senior managers were supportive and visible. Senior nursing staff including matrons told us they carried out daily walk rounds of patients and the units to ensure they were aware of any patient and staff issues or concerns.
- Maple and Cedar wards had joined to set up a team leader's day scheduled for July 2016. The basis of this was to empower senior nursing staff to lead a junior team and challenge poor performance to ensure no compromise of good patient care.
- Some staff indicated concerns over senior medical staffs' behaviour in both the heart and lung division. Staff aired concerns and frustration that senior medical

staff did not always take their ideas and requests into account even if the suggestions may improve the service. Staff felt raising the issue would not change things in the long term.

Vision and strategy for this service

- Staff described the trusts vision and strategy as being the UKs leading specialist centre for heart and lung disease. They told us that services would continue to develop though research and clinical practice to improve the health of people across the world and to help patients when others cannot.
- Although staff we spoke with did not know of a specific vision for the surgical directorate they told us the trust values of "we care" "we respect" and "we are inclusive". Staff held cards with the trust values on them that they showed us during our announced inspection. Staff told us they work to these values on a daily basis to ensure patients receive the highest quality of care.
- On each ward, the Nursing strategy for 2015-2018 was visible and included mandates that staff should treat patients as they would wish to be treated. We saw Maple ward had its own vision, which was on a board in the main corridor. In theatres, the vision hung above the main information board so all staff could be reminded of what the trust was working towards.
- The transplant unit had a yearly peer review to highlight service priorities, which was undertaken the week of our unannounced visit. A peer review allows other specialist centres to come to the hospital and review its care. It assesses areas of excellence and concern. The 2015 review highlighted issues surrounding capacity and variation in surgical activity.
- The peer review also indicated areas of outstanding practice including the one stop MDT follow up clinic, the high dependency facilities on the transplant ward and good psychology provision.

Governance, risk management and quality measurement

- There were robust governance and risk management strategies in place within the hospital in place to keep patients and staff safe.
- The hospital held a monthly governance day where no elective surgery took place. Medical staff attended

Surgery

quality and patient safety outcome meetings for both heart and lung divisions. We reviewed the minutes of these meetings that included discussions about the risk register and cancer reviews.

- During the governance day, medical teams assessed audit data and held teaching sessions for junior doctors including simulation training. This aimed to improve staff knowledge and confidence in dealing with difficult situations such as a patient in cardiac arrest.
- Cherry Tree ward staff used the governance day as a teaching day for nursing and healthcare staff. The practice facilitator ran the day and the agenda for these meetings included mandatory training assessments.
- Managers across the service discussed risks associated with their wards at several different meetings. Matrons across the hospital held a meeting on a Friday where they raised incident reports and other safety issues. Ward sisters attended a monthly cross-site meeting where they discussed learning experiences and incidents from all directorates.
- Ward managers held ward meetings on a monthly basis. On maple ward, there were two sessions to encourage staff to attend, as the ward would often be too busy to release all staff all at once. They told us this had improved attendance.
- Risk registers were available at a trust and divisional level and some wards had risk registers. The ward risk registers we viewed had yearly updates but staff told us these could be updated more often if needed. They included items such as new staff members, falls and the lack of space.
- The trust wide risk register had a failure to detect deteriorating patients included as a moderate risk and completion of the WHO five steps to safer surgery checklist completion as a low risk. Senior staff in both theatres and wards could not tell us what further steps they were taking to improve on these areas of care. Senior staff had agreed that senior medical team members did not have to attend the team brief in theatres, which the risk register states is essential. This highlighted that these areas were not being managed effectively to keep patients as safe as possible.
- On Maple ward senior staff held team days twice yearly. This involved a senior member of staff and their team of junior staff attending a protected learning day for

training. Speakers included senior managers such as the director of nursing. Staff told us this was a good way to learn who senior managers were and gain insight into their role.

- Following an audit on Cherry Tree ward, the senior sister found staff did not feel confident in how or when to report incidents. The practice facilitator and senior sister carried out training around incident reporting. They were planning to complete a re-audit before the end of July to assess staff learning.
- Cherry Tree ward had produced a “procedures handbook” which nurses could refer to if they were unsure of certain pre and post-operative care. This helped make the unit safer as they often had many complex procedures at the same time. The handbook gave nurses a point of reference in the absence of medical staff or senior nurses.

Culture within the service

- We found surgery staff to be passionate and committed to providing patients with the best service and care possible.
- Ward staff felt valued members of their ward units. Staff said they had not experienced bullying and harassment and felt there was a culture of openness and honesty.
- Junior nursing staff showed great respect for their seniors. One senior nurse said, “I have the greatest respect for our matron.” We saw senior nurses assist junior nurses with basic patient care such as washing and dressing.
- In theatres however, there were on-going concerns about senior surgeons within the transplant service. Staff told us they feel pressurised to stay late at times and the way the surgeons spoke with them was disrespectful.
- Ward medical staff conveyed that their rotas could be very stressful and senior medical staff did not always understand this.
- Some clinical staff felt surgeons did not listen to their ideas for the way the service could improve or assist them in drawing up new protocols. They felt to attempt to discuss this would not change anything.
- All staff completed exit interviews when leaving employment within the hospital. Information we reviewed from the theatre department noted positive staff experiences with many staff commenting they were sad to leave.

Surgery

Public and staff engagement

- The surgical directorate had excellent engagement with both staff and patients. There were examples of learning from patient comments and involvement of the local population.
- There was evidence of public engagement via “you said we did” cards. On Maple and Cedar wards, patients had stated they had nowhere quiet to sit or have difficult discussions. Staff redesigned an old office into a quiet and bright sitting room. They named it after a previous well-respected ward sister.
- The Transplant ward held a regular Patient Peer Support Group run by a senior transplant nurse. Previous transplant patients would come to the ward to talk to current inpatients. A discussion around improvements within the group led to the ward buying a patient coffee machine. They introduced all-day menus to reduce complaints around food service and choice.
- Monthly newsletters on the surgical unit allowed staff to nominate an “employee of the month”. Staff told us they felt a sense of pride when nominated.
- On the transplant unit, a violinist would come weekly and had learnt to play specific songs at a patient’s request.
- Some of the transplant units previous patients set up “The Harefield Hamsters”. It is a charity, which aims to provide support and activities to patients to improve their quality of life. Leaflets were available so that patients could join if they wished.
- On Maple ward there was a patient education board with topics such as preoperative preparation and useful contacts post discharge. This helped patients to take ownership for their conditions and feel less isolated on discharge.
- The physiotherapy department had erected posters every 10 meters along Cedar ward each with an interesting fact to encourage patients to mobilise and prevent post-operative complications such as chest infections.
- In theatres, a “traffic light” system was implemented which encouraged staff to write down concerns from their day anonymously. The aim of this was to solve problems, tackle challenges and discuss opportunities to improve practice.
- The theatre department held an open day in September 2015 in which over 400 staff, patients and members of the public attended. They looked at technologies and

techniques used in the operating theatres. Members of the theatres team were on hand to demonstrate various mechanical devices and procedures including ventricular assist devices (VADS), endoscopic vein harvesting (a surgical technique used in conjunction with coronary artery bypass surgery) and video assisted thoracoscopy (thoracic surgery performed using a small video camera).

- Local schoolchildren had the opportunity to attend and theatre open day held in December 2015. Children had the opportunity to dissect pigs’ hearts and learn about the hospital history.

Innovation, improvement and sustainability

- The VAD team implemented steps to reduce infections for patients with VADs following high infection rates. Patients had to email weekly pictures of their wounds to ensure fast detection of infections or poor dressing technique. A take home DVD for patients giving systematic dressing instructions was developed. Other centres across the UK have used the DVD due to its effectiveness in reducing infection rates.
- A recent communication from an Italian centre had asked them to share their dressing protocol, as their results had been so effective.
- VAD team members were some of the most highly skilled in the UK. They could care for patients undergoing surgery for the insertion of an artificial heart without the need for the company who make the heart being present. No other service in the UK can provide this without the company being present.
- The day care unit was trialling a new text-message feedback service co-ordinated by the Friends and family team. We saw the results of this, which were 96%, and above on a monthly basis. Staff members personally named in feedback received a certificate for their nursing portfolio.
- Audit has shown a marked improvement in the number of surgical site infections (SSI) and data from January 2016 showed that for coronary artery bypass surgery there were no SSI reported and infections on wound swabs had decreased. The trust had put several measures in place to reduce the infection rates. All cardiac patients have a wound photograph at discharge that can be monitored by the patient, their GP and the hospital. Staff had training on correct measurements for women requiring a specialist bra post sternotomy

Surgery

surgery (this is an incision down the middle of the chest from top to bottom). The bra is a specialised compression garment that helps reduce pain and assist wound healing.

- Three short films on wound infection prevention were developed with Trust patients, the multidisciplinary team and Public Health England colleagues and were being shared with other NHS trusts to encourage good practice.
- The Brompton Harefield infection score (BHIS) was developed to predict a patients risk of having a post-operative wound infection following cardiac surgery. It allows employment of prevention strategies

to reduce the risk of having an infection post-surgery. In depth research into the BHIS has shown it is an effective tool in predicting the risk of SSI making care safer for patients.

- The transplant unit won the runner up of the Trust Quality improvement programme with a project on the “Transition and holistic care of young people in lung transplantation”.
- The Harefield transplant team pioneered the Organ Care System in cardiothoracic transplantation. This is a method for transporting and optimising potential donor hearts. Most other cardiothoracic transplant services have adopted this system. A lung transplant version has also been utilised.

Critical care

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

Harefield Hospital is a heart and lung specialist centre and part of the Royal Brompton and Harefield NHS Foundation Trust. Critical care services at Harefield Hospital include 18 beds in an intensive therapy unit (ITU) for level three patients and 10 beds in a high dependency unit (HDU) for level two patients. A seven-bedded intensive therapy recovery unit (Recovery) provides care and treatment to level three patients in six bed bays and a side room. Three beds are allocated for cardiothoracic patients and four beds for overnight patients. There is a negative-pressure side room. This unit is connected to the main ITU and is staffed by the same team.

There are an additional four HDU beds, including one side room, on Maple ward and 12 HDU beds on Acorn ward. Maple ward is one of the two wards making up the Adult Surgical Unit (ASU) at Harefield hospital. The beds on Maple ward are shared between surgical patients and private patients.

ITU, HDU and Recovery have the same matron. Maple and Acorn HDUs are not under the same matron as ITU, HDU and Recovery, however all the critical care wards (ITU, HDU, Recovery, Maple and Acorn) are under the remit of the same general manager, divisional director and lead nurse.

Between June 2015 and June 2016 ITU treated 1,547 patients with an occupancy rate of 97%. HDU wards treated 1,982 patients.

To reach our judgement, we spoke with 34 members of staff including nurses, doctors, healthcare assistants and allied health professionals. We also spoke with seven patients, three relatives and looked at over 43 individual pieces of evidence.

Critical care

Summary of findings

We rated this service as good because:

- Patients were protected from avoidable harm. The working culture enabled staff to report incidents confidently and there was evidence of learning from incidents.
- Nurse and medical staffing consistently met the national best practice guidance of the Royal College of Nursing and the Faculty of Intensive Care Medicine.
- A team of practice facilitators and a practice educator worked in critical care to provide specialist training and learning to the clinical teams.
- Staff had a good understanding of safeguarding principles and knew what to do to keep people safe. Staff had access to specialist support if they needed help with safeguarding or child protection.
- Staff demonstrated good knowledge of the duty of candour and were able to explain when they would use this. Records we looked at showed us staff acted according to best practice.
- Care and treatment was delivered in line with national evidence based practice including from the Royal College of Nursing and the National Institute for Health and Care Excellence.
- Staff responded and managed deteriorating patients in a way that managed risk and recorded observations regularly.
- A critical care outreach team provided a follow-up service for patients after they were discharged from ITU.
- There were clear governance structures in place and staff told us leaders were visible, supportive and approachable.
- Staff were clear on the strategy for critical care and knew what their role was in achieving this.

We also found some areas of outstanding practice. These were:

- The work of the practice education team (four practice facilitators and a practice educator) where they provided teaching, learning support and supervision to staff.
- Innovative practices by the critical care outreach team (CCOT), for example spearheading an acute kidney injury reduction strategy in thoracic surgical patients following a large number of acute kidney injury referrals.

However:

- Mandatory training for safeguarding fell below the departmental target of 75% for safeguarding children level two in HDU. Mandatory training also fell below the 75% target for infection control (70%) and for equality and diversity(70%) in ITU.

Critical care

Are critical care services safe?

Good



We rated safe as good because:

- Staff used the incident reporting system effectively and felt their opportunities for learning from incidents helped them to develop their professional practice and improve clinical safety. Senior staff conducted a root cause analysis where necessary to prevent errors or mistakes happening more than once.
- Staff demonstrated an understanding of their responsibilities under the duty of candour and how this enabled them to be open and transparent about safety with patients and relatives. There were established processes in place to assess and respond to patient risk.
- Medicines and controlled drugs were stored, prescribed and administered appropriately. Staff compliance with hand hygiene and infection control protocols was audited monthly. Results demonstrated high standards of infection control practices and this was further confirmed during our observations of practice. Staff had good knowledge of safeguarding principles and escalated concerns to specialists when needed.
- Staff documented daily safety checks of resuscitation trolleys and equipment. However, checks were not always consistent as we found out of date medicine in one of the trolleys.
- Critical care units consistently maintained adequate nursing staff for each shift and this was in line with Royal College of nursing standards. We also observed effective handovers and shift changes.

However:

- There was no consultant intensivist dedicated to HDU at the weekend and this was in breach of Faculty of Intensive Care Medicine (FICM) guidance on medical cover. There were no consultant intensivist led multidisciplinary clinical ward rounds on HDU at the weekends which is also a requirement by FICM. The unit mitigated this by having an on-call surgical registrar and a surgical senior house officer cover HDU at weekends. ITU and theatre consultants also provided anaesthetic cover. Furthermore, a critical care outreach team supported HDU at weekends, which partially mitigated the reduction in medical staff.

Incidents

- Staff used an electronic system to submit incident reports. Between May 2015 and March 2016 critical care reported 370 incidents. Senior staff were responsible for allocating a named individual to investigate each incident, which they tracked to help identify trends and themes. For example, the largest number of incidents reported related to medication errors. Staff received individual feedback from incident reports and outcomes were disseminated through the staff critical care newsletter which comes out every two weeks. If the outcome affected staff outside of critical care, e-mail memos were sent to heads of department and senior staff across the trust.
- There were no 'never events' and two serious incidents between May 2015 and March 2016. 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.
- There was evidence of learning and changes in practice following incidents in some cases. For example, following an incident where essential stock was missing from a bronchoscopy trolley in ITU a decision was made that ITU would take over the responsibility of stocking and maintaining the bronchoscopy trolley.
- Practice facilitators and a critical care pharmacist investigated medicine errors and supported the member of staff involved to conduct a reflective exercise. This was used to identify what contributed to the mistake and how it could be avoided in future.
- The practice education team used the outcomes from incidents to contribute to learning topics on study days and during bedside teaching sessions.
- A patient safety group met annually to review incidents and identify trends. This was a collaborative process amongst staff during which they considered changes to policy or practice to improve safety.
- Quality and safety meetings took place monthly on the intensive therapy unit (ITU), high dependency unit (HDU) and in Recovery. Staff discussed incidents, errors and risks in these meetings. This helped to drive forward improvements in safety. For example, in the quality and

Critical care

safety meeting for May 2016 an incident pertaining to the administration of a medicine to a patient who had an allergy to that medicine was discussed. The action plan was for staff to investigate whether automatic flags could be added to the electronic prescribing system when drugs with a documented allergy were prescribed for a patient.

- Staff demonstrated an awareness of the duty of candour and how it applied to the critical care environment. We saw documented evidence of examples of when staff had appropriately followed the duty of candour requirements, such as discussing clinical errors with patients and relatives. Duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person.
- Consultants led a monthly morbidity and mortality meetings where patient deaths were discussed and assessed for improvements in practice.

Safety thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients. This included new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence.
- Critical care services participated in the NHS Safety Thermometer. This information was clearly displayed at the entrances to units and included details on Clostridium Difficile infections, patient falls, medication errors, pressure ulcers and methicillin resistant Staphylococcus aureus (MRSA) infections.
- Two safety thermometer link nurses were in post in ITU and had oversight of data collection and practice improvement.
- The trust had a policy which documented and described the measures for the prevention, diagnosis and of venous thromboembolism (VTE) in patients admitted to the Royal Brompton and Harefield. There were no new VTEs within ITU or HDU wards during the reporting period but the recording of VTE risk assessments was inconsistent.

Cleanliness, infection control and hygiene

- The trust had an infection control policy which could be accessed via the intranet. Staff knew how to access this policy and we saw they adhered to this in practice.
- There were hand gels at entrances and exit to wards but these were not always in plain sight.
- Staff used bright green 'I'm clean' tape to indicate when an item of equipment had been cleaned and sanitised. However, this process was not used consistently. For example, we found a commode in the clean utility area ready for use and with an 'I'm clean' sticker attached. This item was soiled with potentially infectious human waste. We spoke with the nurse in charge who removed it. An external contractor provided cleaning services, which were signed off daily by the nurse in charge. It was not clear why this item had not been appropriately disinfected and cleaned.
- The trust's minimum hand hygiene compliance standard was 90% and this was audited monthly using a five-point check. This included hand washing before and after specific tasks, including patient contact as well as compliance with the bare below the elbow policy. Monthly hand hygiene audits took place. In May 2016, the HDU was 90% compliant in this audit, which met the trust's minimum requirement. Staff we spoke with were aware of the result but did not know what improvements needed to be made. In the same month, the hand hygiene audit result for the Acorn ward HDU was 86%. Hand hygiene in ITU had declined from 100% in May 2016 to 90% in June 2016. To address this, an automated hand hygiene training and compliance system had been put in place. This helped staff to ensure their hand washing technique was compliant with trust standards. The monthly audit was increased to weekly to raise staff awareness of the importance of this.
- Monthly cleaning audits were completed in clinical areas. In May 2016 the ITU scored 96%. We requested cleaning audit data for HDU but the trust was unable to provide it.
- A patient in the ITU had developed a strain of multi-resistant bacteria. In response to this, senior nurses implemented a deep-clean and total systematic cleaning protocol for the whole unit. This involved the closure of side rooms and bed spaces and replacement

Critical care

of mattresses. This meant some patients had to be moved and this was done within defined protocols and with appropriate risk assessments. The entire process ensured the risk of cross-infection was minimised. We spoke with two members of housekeeping decontamination staff who demonstrated a good understanding of deep clean procedures.

- In ITU and Recovery infection control meetings took place every three months. Quality and safety meetings took place every month in ITU, Recovery and Maple wards. During both these meetings infection control was discussed and any incidents relating to infection control would be discussed and resolved.

Environment and equipment

- A dedicated nursing officer was in post for managing medical gases. This individual had responsibility for safety and had been trained to shut off gas supplies in the event of an emergency.
- The HDU had an on-site x-ray machine and stores of positive airway pressure equipment, such as Bi-PAP and C-PAP.
- Three side rooms were available in the HDU and were used for barrier nursing for infection control purposes. However, the side rooms were not equipped to deliver negative pressure.
- Critical care areas were compliant with the Control of Substances Hazardous to Health regulations. This included safely stored and locked chemicals.
- Thought and care had been put into protecting the privacy of patients in clinical areas. For example, patient allocation boards were on display that showed which members of staff were responsible for which patient. These included important notes such as if a patient had dementia, specific nutrition needs or had a discharge date. There was a privacy screen on each board that covered personal details that could help to identify people.
- A biomedical mechanical engineering (BME) team provided equipment support on-site Monday to Friday from 8am to 6pm. Outside of these hours the BME team at the Royal Brompton provided support. A dedicated critical care technician was available Monday to Friday and worked with the BME team to ensure equipment was serviceable.

- Sharps bins ready for disposal were stored in a sluice room in HDU, which meant the area was not compliant with EU waste regulations.
- There was visible damage to the floor in the ITU. Tape was used to cover up this damage. This had been entered as a low risk in the risk register. There were plans to fix the floor during refurbishments.
- Staff documented daily safety checks on resuscitation trolleys in the critical care units. However, checks were recorded inconsistently. For example, one trolley contained an out of date stock of naloxone, a medicine used to treat drug overdose. We made the resuscitation lead nurse aware of this as they were on the ward at the time and they took steps to remedy this.

Medicines

- Practice facilitators conducted initial assessments for some medicine administration amongst nurses. This included the administration of oral drugs and subcutaneous drugs. New nurses were required to demonstrate competency in a minimum of three observed practical sessions.
- In 2015/16 the hospital rated the HDU in the top three of clinical areas in the hospital for best medicines management.
- Staff should have documented twice-daily checks on controlled drugs (CDs). However, we found that there were days when staff had not signed a check of the drugs. We raised this with the matron who looked into this and told us that drugs had been checked but staff had omitted to sign in the folder on the dates we looked at. In the ITU, HDU and Recovery, CDs were stored correctly and were all within their safe shelf life.
- Of all the incidents reported between May 2015 and March 2016, 46% were medication errors. Practice facilitators and the critical care pharmacist investigated medication errors on the unit. This meant that trends could be tracked and factored into the training offered on the unit by practice facilitators.

Records

- Staff completed a series of risk assessments for each patient on admission, including for falls, malnutrition and venous thromboembolism. However, VTE risk assessments were documented inconsistently in patient records. For example, in some records VTE assessments were missing or incomplete.

Critical care

- Drugs were prescribed electronically and this information could be accessed easily.
- Time-critical observations, such as hourly or two-hourly were recorded consistently and accurately.
- Physiotherapist and dietician input were also consistently recorded in the patient records.

Safeguarding

- Staff had access to the trust's safeguarding policy on the intranet, which included guidance on how to access urgent specialist support.
- Staff demonstrated good knowledge of safeguarding and were able to give examples of what might constitute a safeguarding concern. Most staff we spoke with had not initiated a safeguarding referral themselves but told us that they would speak to the matron if they were concerned about whether something needed escalating as a safeguarding concern.
- Safeguarding training at level one was mandatory for all staff in the hospital and there was a minimum target of 75% of staff for up to date training. In ITU, 98% of staff had up to date safeguarding children level one training and 70% had up to date safeguarding adults level one training.
- In HDU, 97% of staff had up to date safeguarding children level one training and 83% had up to date safeguarding adults level one.
- In HDU only 60% of staff had completed safeguarding children level two training. This did not meet the trust's target of 75%.
- Training data provided by the trust showed that critical care staff were trained up to level two in Safeguarding Children training.
- There was evidence of a positive working relationship with the local authority. For example, when staff were concerned about a patient's mental health, they contacted the safeguarding team. This enabled them to share information clinical staff had not previously been aware of. This that helped staff to treat the patient more effectively.

Mandatory training

- Staff from the ITU and HDU attended mandatory training days together. This helped to improve cross-unit working practices and understanding.

- Mandatory training was provided in relation to the hospital as well as in relation to the critical care environment and was delivered through e- learning and face-to-face sessions. Staff had protected time to complete training.
- Staff were complimentary about the quality of mandatory training they received and told us the sessions were useful because they were directly applicable to their day to day work. They told us that senior staff monitored training and would remind them when training was due.
- Figures for mandatory training showed that overall compliance with training for HDU staff was at 93%, which was better than the trust target of 75%. Staff also met or exceeded the trust's minimum training target in safeguarding adults level one (83%), safeguarding children level one (97%), infection prevention and control (83%), moving and handling (100%), information governance (83%), equality and diversity (83%), medicine management (100%), medical gas (100%), fire safety (100%), and basic life support (100%).
- In HDU the 75% target was not met for Safeguarding Children Level 2 (60%). We requested training data for Acorn ward, Maple ward and the Recovery ward but the trust was unable to provide it.
- In ITU staff met or exceeded the trust training target for information governance (100%), medicine management (100%), moving and handling (100%), safeguarding children level one (98%), basic life support 100%, health and safety (100%), and fire safety (100%). This target was not met for equality and diversity (70%) and infection control (70%).

Assessing and responding to patient risk

- Staff in wards and critical care used the National Early Warning Scores (NEWS) system to identify and monitor patients who were deteriorating.
- During one day of our inspection we observed the clinical team in ITU respond safely and quickly to a high risk situation. This involved two patients in separate side rooms experience a cardiac arrest within 60 seconds of each other. One patient was highly infectious and cared for using extracorporeal membrane oxygenation (ECMO). The ITU and recovery nurses in charge, on-call crash team, bedside nurses, consultants and critical

Critical care

care outreach team responded within seconds. The response to patient risk from the multidisciplinary team was exemplary and both nurses in charge led their teams with confidence and empowerment.

- ITU staff conducted safety huddles twice daily, using the safety, background, assessment and recommendations (SBAR) tool. This was used in addition to NEWS scores to monitor patients who were at risk of deteriorating.
- The hospital had a Critical Care Outreach Team. The team were available between 8am to 8pm seven days a week. Outside of these hours, an anaesthetic registrar provided cover. The outreach team followed up patients in HDU after discharge from the ITU and supported ward staff in managing on-going clinical issues and in maintaining continuity of patient care. Staff told us that a majority of readmissions to the unit were as a result of the outreach team effectively identifying patients who were at risk of deteriorating.
- ITU, HDU and Recovery had monthly patient safety and quality and safety meetings. HDU on Maple ward had a monthly quality and safety meeting. These meetings were an opportunity for multidisciplinary teams to discuss and respond to patient risk. Prior to these meetings colleagues at the Royal Brompton site were contacted in order to encourage cross site working. The minutes of meetings showed that staff came up with action plans to discuss any issues arising from the meetings.
- Staff undertook life support training at a level appropriate to their role and responsibilities. All staff who worked in clinical areas, including non-clinical staff such as administrators and housekeepers, had basic life support training. Nurses who worked in critical care for over 18 months were trained in intermediate life support. All sisters, practice facilitators and the practice educator had advanced life support training. Senior staff also had ALERT training, which is a multiprofessional approach to improving outcomes for critically ill adults.

Nursing staffing

- Nurse staffing levels consistently met the requirements of the Royal College of Nursing (RCN) and the Faculty of Intensive Care Medicine (FICM). The nurse to patient ratio in the ITU and Recovery was maintained at 1:1 and in the HDU; the nurse to patient ratio was always 1:2. There was always a supernumerary nurse in charge in each area. This included the Maple ward HDU and Acorn ward HDU. There was at least one additional

supernumerary nurse coordinator on each shift. Teams of senior sisters and deputy sisters led critical care nursing. ITU nurses worked in the recovery unit and had appropriate training for this. A nurse in charge was on shift at all times in both units.

- Nurse handovers took place twice daily on each unit. Band six nurses on a leadership development pathway were encouraged to lead the handovers. The senior nurse in charge used the handover to allocate staff to patients based on their skill mix and competencies. Nurses could also request to work with the same patients to provide continuity of care. This was particularly important where a patient stayed in a unit for an extended period of time.
- A team of healthcare assistants supported nursing staff and a band four nurse practitioner was available in HDU. This individual was always supernumerary and provided support to other nurses such as taking and recording vital signs and observations and taking out lines and drains.
- All new nurses were offered the opportunity to undertake a preceptorship programme. This was also offered to experienced overseas nurses who wanted to improve their skills in NHS practices. The preceptorship programme included a structured period of supervision followed by a formal appraisal. This helped to ensure all registered nurses worked from an established skill mix.
- Units used both bank and agency staff to cover shifts they could not fill with their own permanent staff. Agency nurses undertook an orientation prior to working in critical care. They were also given training and access to the electronic patient record system so they could work more safely with patients.
- Data received from the Trust showed that in March 2015 12.4% of staff used in ITU were bank or agency staff and for HDU this figure was lower at 2.5%.
- On the HDU on Maple bank and agency staff covered nine shifts in the month of April 2016. This meant that bank and agency staff covered 15% of the shifts on HDU Maple ward in April 2016. In all cases the proportion of agency staff on shift at one time was lower than the 20% maximum established by the RCN.
- Two nurse specialists in extracorporeal membrane oxygenation (ECMO) treatment worked in critical care, supported by a team of nurses who had undertaken ECMO training.

Medical staffing

Critical care

- Consultant and other doctor staffing levels met the requirements of The Faculty of Intensive Care Medicine (FICM) at all times in the ITU and Recovery. Consultant to patient ratio never exceeded 1:8 and twice-daily consultant-led ward rounds took place. Patients were always seen by a consultant intensivist within 12 hours of admission and two consultants were available 24-hours, seven days a week. This was also covered by an on-call rota where a consultant intensivist was available within 30 minutes of being called.
- In HDU, a consultant intensivist was available Monday to Friday from 9am to 6pm. Outside of these hours an on-call surgical registrar and surgical senior house officer covered the unit. On a weekend ITU and theatre consultants provided anaesthetic cover. This did not meet the FICM guidance which states that a consultant in intensive care medicine must be immediately available 24 hours a day, seven days a week to attend within 30 minutes. Following the inspection the Trust informed us a consultant intensivist is currently available 24 hours a day, seven days a week to review potential ITU admissions from any part of the hospital including the HDU.
- Consultants from medical and surgical specialties visited the HDU on a weekend to see their own patients and a senior house officer and an ITU doctor conducted a daily ward round. However, this did not meet the minimum requirements for medical staffing of FICM. The Critical Care Outreach Team supported HDU on a weekend, which partially mitigated the reduction in medical staff. We asked staff about this. They said doctors were always available on a weekend if needed urgently but hospital ward rounds often took so long there were no doctors on the unit until the afternoon.
- Medical handovers took place twice daily and were led by a consultant intensivist in ITU. The consultant on duty led the medical handovers in Maple HDU and Acorn HDU. However, there was no consultant intensivist dedicated to the HDU at the weekend and FICM requirements for handovers were not always met. The guidelines state that consultant intensivist led multi-disciplinary clinical ward rounds within intensive care must occur every day including weekends and national holidays.
- A surgical consultant conducted a ward round for their patients in critical care. There was a good working relationship between the surgeons and the critical care team. This meant that critical care consultants would be

jointly responsible for the surgical patients when they were in ITU or HDU. We witnessed several good examples of interdisciplinary discussions about patients on ITU.

- Two specialist registrars covered the Acorn ward HDU and there was a consultant on call at all times. Out of hours, a senior house officer shared with another medical ward provided cover.
- There were established arrangements for input from consultants in specialties not based in Harefield, such as gastroenterologists.
- Data received from the trust showed that in March 2015 there was no use of doctors from bank or agency.

Major incident awareness and training

- Fire and evacuation plans were in place for all areas. Staff undertook an annual simulated evacuation in which their performance and response in an emergency was assessed and used to improve training. Each unit had a fire warden who held day-to-day responsibility for fire safety.
- Aggression and violence in critical care could occur as a result of patients' delirium and confusion. Staff told us this was a fairly common occurrence but they had not received training to handle such a situation.
- Critical care units were secured with electronically controlled access and security staff were available via the bleep system 24-hours, seven days a week.

Are critical care services effective?

Good



We rated effective as good because:

- Staff used national best practice guidance to deliver effective care and treatment. This included guidance issued the National Institute of Health and Care Excellence, the UK specialist Rehabilitation Outcomes Collaborative and the Faculty of Intensive Care Medicine.
- Care was delivered by competent and experienced nursing and medical staff who were regularly assessed in their clinical skills.
- Staff were qualified and had the skills they needed to carry out their roles effectively and in line with best practice.

Critical care

- Staff were supported to deliver effective care and treatment through supervisions and appraisals.
- Critical care staff were knowledgeable about the issues pertaining to consent and deprivation of liberty safeguards.
- Care bundles were regularly audited as part of an on-going system of monitoring treatment outcomes and best practice.
- A multidisciplinary team supported critical care clinicians, including physiotherapists, dieticians, occupational therapists and speech and language therapists. Staff from these teams contributed to care and treatment plans and attended ward rounds to ensure the care team worked together to promote recovery.
- There was cross site working between Harefield critical care and Brompton hospital critical care particularly in relation to nursing education. Consultants at Harefield also dedicated some time to work with the Royal Brompton consultants especially in relation to extracorporeal membrane oxygenation (ECMO).

However:

- There was inconsistency in patient observation scoring, including the visual infusion phlebitis (VIP) score and scores relating to confusion and delirium.
- Critical care services had not historically submitted data to the intensive care national audit and research centre (ICNARC). This meant patient outcomes and the quality of care was not readily comparable to national standards. However, staff had started to contribute to this just before our inspection, which would help them to benchmark practices in the near future.

Evidence-based care and treatment

- Staff used the visual infusion phlebitis (VIP) score for monitoring infusion sites in line with the Infusion Nursing Standards of Practice (2011). This meant they monitored infusion sites in a way that prevented phlebitis, an inflammation of the vein. The VIP tool was not used consistently in all areas. For example, a May 2016 Acorn ward HDU audit showed compliance with the VIP tool to be 71%. Staff told us this had been discussed at their last team meeting and plans to

improve it implemented. However, during one day of our inspection one patient's records indicated their VIP score had not been checked for over 12 hours, when this should have been checked every four to six hours.

- Staff completed an audit of the frequency of use of the confusion assessment method in ICU tool (CAM-ICU) in long-term patients who were in the unit for 10 days or more. The audit found staff scored long-term patients 60% of the time during the day and 74% of the time during the night. Staff received feedback from this and a re-audit to check improvements was planned for 2017. A CAM-ICU audit was also undertaken to assess how many patients received an assessment in the first 10 days of admission. This found only 26% of patients had a CAM-ICU during this period and 9.2% had two CAM-ICUs. The trust standard was for an assessment to be completed within 24 hours of admissions and senior staff used this audit to improve this with urgency.
- The critical care unit had not previously submitted data to ICNARC. Senior staff had implemented a plan to begin submitting data, which meant they would be able to benchmark their clinical performance against other units nationally in the future.
- Critical care was part of the North West London Critical Care Network. This meant quality of care and patient outcomes were compared with other units in the network. Staff also participated in peer audits where clinicians from other units would assess care and treatment across network standards.
- Critical care at Harefield was involved in the National Cardiac Benchmarking Collaborative (NCBC) since 2010. Submitting data to NCBC was another way by which the critical care unit benchmarked patient outcomes.
- Staff completed quarterly audits on the use of care bundles. The most recent audit was for October 2015 to December 2015. The audit looked at venous thromboembolism (VTE), gastrointestinal prophylaxis, head-up tilt, sedation hold, subglottic aspiration, cuff pressure, and chlorhexidine mouth wash. During this period there was 96% compliance with care bundles.
- Junior doctors were routinely supported to conduct audits as part of quality improvement. We saw evidence

Critical care

of the involvement of junior doctors in audit and research projects. For example, junior doctors had been involved in an audit project on the use of a medicine known as Sugammadex in thoracic surgery.

Pain relief

- Critical care had implemented the Faculty of Pain Medicine's Core Standards for Pain Management (2015). This included an assessment and documentation of pain score at regular intervals.
- Staff completed pain scores at least four hourly and more frequently in patients with more complex conditions or treatment. The recording of pain scores was however not consistent.
- A pain management team was available between 9am and 5pm Monday to Friday. The team was made up of a lead nurse specialist who worked across two hospital sites and a clinical nurse specialist. These nurses worked with consultant anaesthetists, specialist nurses, physiotherapists and pharmacists as part of multidisciplinary team to ensure pain needs were met. Consultant intensivists and the critical care outreach team (CCOT) were also able to prescribe pain medicine.
- Patients told us that pain was well controlled and that staff responded quickly when they asked for pain relief.

Nutrition and hydration

- Staff completed the malnutrition universal screening tool on a weekly basis for HDU patients and more frequently for ITU patients if needed. Dedicated dietetics support was available daily.
- Staff referred HDU patients to a dietician where necessary. For all ITU patients, a dietician attended daily in order to conduct assessments. Out of hours, consultants made decisions regarding feeding.
- We looked at a sample of patient records and found information on nutrition documented in these notes.

Patient outcomes

- There was evidence of staff involvement in activities to monitor and improve patient outcomes. For example, a procedure called venovenous extracorporeal membrane oxygenation (VV ECMO) was used for patients awaiting lung transplantation if they developed respiratory failure while waiting for a suitable organ. This procedure was a way to expand recipient opportunities by extending the

lives of patients with end stage lung disease long enough for organs to become available. A multidisciplinary ITU follow-up clinic supported these patients following discharge.

- Long-term patients were included in the evening ward round on HDU, which included checks that on-going needs were being met.
- Each bay in ITU had an additional nurse who worked as a bay leader. There were three bay leaders on each shift and they acted as communication links between bedside nurses and the nurse in charge. Bay leaders held their own briefing after the afternoon medical handover, which meant they were aware of treatment plans and care bundles. This role provided extra support to bedside nurses and provided improved safety for patients. We spoke with staff who undertook this role. They said because they knew what was happening with each other's patients, when someone deteriorated or a member of staff needed some help, they were immediately available.
- Staff audited the bay leader initiative for effectiveness. This took place 12 months apart, in January 2015 and January 2016 and focused on recognition, usefulness and communication. In the first audit round, only 8% of staff said bay huddles always occurred. In the second round, 80% of staff said bay huddles occurred. There was also an improvement in how many staff rated teamwork as good, from 75% in the first audit to 89% in the second audit.
- Risks associated with VTE were not always appropriately managed. For example, in the Acorn ward HDU, staff did not check calf measurements daily for signs of VTE. Patients were prescribed medicine in relation to this but there were no on-going checks.

Competent staff

- A team of four practice facilitators, with support and oversight from a practice educator, provided teaching and learning support as well as supervision. This team also supported staff to complete critical care competency booklets when they started in the department or were ready to progress their development.
- New nurses were offered a ten week orientation period within a support network of experienced staff. This included a six week supernumerary period and a four week buddying period. During this time they also

Critical care

undertook an academic programme of clinical theory and practice. This programme included competency training on positive airway pressure, which meant they could provide care for patients who were ventilated.

- Staff were offered two dedicated days of protected study time each year. These were used to update mandatory training, update mentors and to provide any new training initiatives. This recently included medicines chart training. Healthcare assistants had study days specific to their role.
- A nurse rotation programme was in place that allowed nurses to choose three out of four directorates to work in. This helped staff to increase their skills in different clinical routines and equipment and to develop time management. After each rotation shift, staff filled in a clinical work diary with the help of their practice facilitator. This was a reflective tool to help assess their progress as well as an audit trail to track training and development.
- Posters were displayed in ITU that listed the name of each member of staff on rotation alongside their current placement and contact details for the senior staff overseeing the programme.
- Well-established nurse development pathways were in place to support progression and professional skills. This included secondments for HDU nurses into ITU and leadership shifts in other areas for deputy sisters on a promotion route. Secondment opportunities were time-limited and part of a structured programme to develop HDU nurse skills while retaining them as permanent members of the team.
- Staff received specialist training appropriate to their responsibilities. For example, HDU staff who worked night shift had been trained in hemofiltration, including setting up and maintaining circuits. Healthcare assistants were trained in the decontamination of ultrasound probes. ITU nurses had received cardiac advanced life support training, which meant they could initiate treatment for a cardiac arrest.
- Practice facilitators and the practice educator team ensured staff received training on new equipment in the department. For example, critical care recently introduced cardiac pacing boxes and staff were being progressively trained in their use.
- Staff underwent an annual appraisal to discuss their work and progress. For the first year of employment, the

practice educator conducted appraisals. This helped staff to monitor their development within the initial education programme. All HDU staff had undergone an appraisal in the 12 months prior to our inspection.

- Nurses had specialist training to enable them to care for patients with extracorporeal membrane oxygenation (ECMO). This included a three day safety management and theory course for ECMO specialists and a one day competency course for ECMO nurses. All band six nurses were ECMO trained and some experienced band fives also had this training.
- The practice educator provided a 'competency clinic' one afternoon a week. This was an opportunity for any member of staff to have their competency in any area checked and receive feedback on this.
- Senior staff encouraged everyone working in critical care to direct their own learning and professional development. This included working with practice facilitators to identify areas of need and to plan research projects that would contribute to practice and knowledge.
- Overall 64% of nursing staff in the ITU had completed a post-registration nursing award in critical care. This was better than the 50% which is recommended in the FICM Core Standards for Intensive Care Units.
- Junior doctors felt well supported by consultants and described their training as well organised and excellent. Junior doctors were able to attend ECMO simulation course for free. An educational supervisor provided support to junior doctors.
- Trainees in ITU and HDU took part in an induction day and there was ongoing teaching for trainees.

Multidisciplinary working

- A team of ITU sisters led the critical care outreach team (CCOT). Staff were based in ITU but dedicated to CCOT and worked in all areas of the hospital to provide care and treatment for deteriorating patients. The CCOT team reviewed HDU patients daily and attended morning bed meetings to help coordinate discharges.
- Staff worked with specialist teams to provide safe care and treatment for patients with complex needs. For example, where patients were treated with a total artificial heart, a ventricular device team provided support.
- We saw evidence of multidisciplinary working during medical handovers and ward rounds. For example,

Critical care

medical handovers were usually attended by a pharmacist, physiotherapist and junior doctors. The transplant team and other specialties, including microbiology, were present when needed.

- A multidisciplinary team of clinical trainers used simulation mannequins to assess staff in airway management and patient transfer skills. A doctor in critical care acted as the simulation lead and the resuscitation team regularly participated. This approach was consistent across specialist teams in their approach to sharing opportunities for learning and development. For example, the circulatory support team conducted regular bedside teaching and checked staff maintained central venous access devices correctly. This team produced a competency book for nurses and taught on the academic programme.
- A critical care team had completed a research project on the integration of multidisciplinary simulations into the clinical education programme. This project included activities with 105 nurses and 10 doctors and highlighted the benefits to patients and staff of such training. As a result of the project, senior staff agreed to appoint two nursing simulation leads and to broaden the scope of simulations to include ECMO and ventricular assist devices.
- The practice education team wanted to increase opportunities for working and sharing knowledge with their critical care colleagues at the trust's Royal Brompton site. A practice educator from the Royal Brompton site contributed to part of the academic programme at this site. In addition, staff from this site planned to work with colleagues at Royal Brompton to develop the provision for citrate as anticoagulation for filters. Cross-site training days had taken place in pain management and epidural care.
- A consultant led a weekly multidisciplinary team meeting for all patients who had been admitted for 10 days or more. The input of patients' friends and family was included in these meetings to ensure friends and family involvement in patient care. Staff involved included those from rehabilitation and therapies, medical and nursing staff.
- HDU nurses worked within seven champion groups. This meant they could specialise in specific areas of care, treatment or unit operation and provide targeted

support to colleagues and patients. Champion groups included tissue viability, end of life care, audits and safety information, health and safety, infection control, diabetes and nutrition.

- Dieticians were involved in patient care and we saw evidence of their involvement and input in the patient records we looked at.
- Multidisciplinary staff conducted detailed handovers when patients moved between wards in the critical care unit or onto other general wards. Details of handovers could be accessed via the electronic system and this meant that staff could easily access these regardless of what ward they were on.
- Physiotherapists contributed to treatment plans for patients in conjunction with the wider multidisciplinary team. Physiotherapists provided up to 45 minutes of therapy per day for each patient, in line with FICM and NICE guidance on the rehabilitation of critically ill adults.

Seven-day services

- The CCOT team was available from 8am to 8pm seven days a week. Overnight, the CCOT handed over to an anaesthetist registrar who carried the bleep for this service and attended wards to help staff care for deteriorating patients.
- Consultant led handovers took place twice a day on the critical care unit from Monday to Friday. However, HDU was not intensivist led at the weekend and as such handovers did not place twice a day, which did not meet FICM guidance. The clinical director was aware of this and consultant intensivist recruitment was underway to rectify it.
- Physiotherapy cover was available between 8.30am and 4.45pm Mondays to Fridays. Outside of these hours the physiotherapy team operated an on-call service.
- The pharmacy service was provided between 9 am and 5.30 pm Mondays and Fridays. On Saturdays, pharmacy provided clinical service to critical care patients between 9am and 3pm. There was an on call pharmacy service on Sundays.

Access to information

- Patient records were primarily kept on an electronic system and there was a computer at every patient's bedside. Information contained in patient records

Critical care

included risk assessment forms, medication charts, care bundles, medical records and any input from physiotherapists and dieticians. However, the unit did use a paper chart to record physiological observations such as blood pressure and pulse rates.

- Staff throughout the hospital were able to access the electronic system which meant that all information was transferred effectively and accessed easily by staff.
- The same electronic system was used at the Royal Brompton site. This meant staff on both sites could access and review records in the event of a patient being transferred between sites.

Consent and Mental Capacity Act

- Staff had been trained in the Mental Capacity Act (2005) including the Deprivation of Liberty Safeguards (DoLS) and could demonstrate how they could be used to protect people. For example, staff used soft hand mittens on a patient who became physically aggressive and tried to hurt themselves. The matron assisted the clinician to apply for an emergency DoLS authorisation from the local authority, which meant a vulnerable patient was cared for appropriately.
- A critical care consultant was the hospital's risk lead and provided specialist reviews for patients who were admitted with a brain injury and who had a DoLS authorisation in place.
- We saw evidence of fully completed mental capacity assessments in patient records and completion was consistent.

Are critical care services caring?

Good



We rated caring as good because:

- During all of our observations, staff offered compassionate, kind care to patients and their relatives.
- Feedback from patients and relatives was consistently positive. Patients felt they were treated with dignity, respect and kindness.
- Patients and relatives were involved in decisions about treatment and information was explained in ways patients and relatives could understand.
- There were appropriate chaplaincy and bereavement services that were available to support patients and relatives when required.

Compassionate care

- Patients described the clinical team as “accessible and visible.” One patient said, “Everyone always introduces themselves, tells us who they are and what they’re doing.” Another patient said, “The nurses really go the extra mile. I feel really well looked after.”
- Patients also told us that pain issues were handled very well and that it was easy to get the attention of staff.
- One patient described their experience with violence related to delirium. They said, “I acted violently when I was delirious but I had no memory of it. The nurse was so kind. She told me what happened and why it happened and why I shouldn’t worry about it.”
- During all of our observations staff demonstrated a high regard for compassion and kindness. For example, staff spoke gently to a patient who was sedated in recovery while providing personal care. When a group of relatives in ITU were very upset, two nurses exercised great discretion in comforting them while trying not to cause distress to the patient.
- The HDU had direct access to a large outdoor landscaped area. Staff were able to take patients outside for sunshine therapy when approved by a consultant and the nurse in charge.

Understanding and involvement of patients and those close to them

- Patients told us they had been involved in discussions about their care and treatment as far as they wanted to be. One patient said, “I’ve been kept informed as far as possible. The doctor respected my wishes when I said there were some things I didn’t want to know.”
- Patients told us the appreciated being involved during ward rounds. One patient said, “Doctors explain things during the ward round, I really appreciate that.”
- The ITU followed the five principles of effectively involving patients and their relatives in their care in line with the NHS Centre for Involvement. Principles included ‘being clear about why we are involving you’ and staff assessed the effectiveness of the programme through stakeholder meetings, questionnaires in the follow-up clinic and patient feedback comment cards.
- Patients' and relatives' input was included at the weekly multidisciplinary review of long term patients. Following the inspection the Trust informed us that an MDT nurse was allocated specifically to facilitate this.

Critical care

- We reviewed a sample of patient records and saw evidence of staff discussing treatment with patients and those close to them.
- Long term ITU patients were routinely offered 'Sunshine Therapy' whereby patients were taken onto the hospital pavilion to enjoy some sunshine. Patients were escorted by a doctor and a member of the nursing team and could also be joined by their friends or family.

Emotional support

- An established bereavement protocol was in place. This included a bereavement pack for relatives if a patient died overnight. Staff left details with the Patient Advice and Liaison Service to contact relatives during daytime hours to offer additional signposting, including to a counselling service.
- Patients told us they felt supported emotionally and that staff were always happy to listen to them.
- A multifaith chaplaincy team was available on-call 24-hours, seven days a week.

Are critical care services responsive?

Good



We rated responsive as good because:

- Services were tailored to meet the needs of individual people and there was flexibility in the provision of care.
- Staff demonstrated a proactive approach to understanding the needs of different groups of people and to deliver care in a way that met their needs and promoted equality.
- Complaints were investigated and changes were implemented as a result.
- Staff used patient diaries to record details of a patients' time in critical care. Patients were given an opportunity to return and ask questions following discharge if they wanted to.

Service planning and delivery to meet the needs of local people

- Critical care services accepted admissions from hospitals across the country. The majority of admissions were planned admissions following elective surgery; however critical care could treat emergency admissions.

Critical care and surgical consultants planned elective admissions as part of a multidisciplinary team and patients were admitted within four hours of the decision.

- Patients were reviewed by a consultant in critical care within 12 hours of admission. This was in line with the Guidelines for the Provision of Intensive Care Services 2015.
- Staff often liaised with professionals in other areas to ensure a smooth transition of care following discharge, for example when a patient was from outside of the local area.
- Organ donation and transplant protocols were in place with on-call specialist nurses available 24-hours, seven days a week. During one day of our inspection staff coordinated a lung transplant within a multidisciplinary team that we saw worked expertly together.

Meeting people's individual needs

- The high dependency unit (HDU) had a patient shower that was equipped with support rails, non-slip flooring and a privacy curtain. This meant staff could enter the shower room from the main corridor whilst protecting patient privacy.
- A bright and airy relative's room was available for visitors to ITU and recovery. Printed information on critical care services, including key staff contacts had been provided. There was also fresh water and a television.
- Staff planned extra resources in advance for elective patients with dementia, a learning disability or communication needs. For example, a member of social care staff or extra healthcare assistants could be scheduled to work with the patient. Staff told us the safeguarding lead was their main point of contact in this area.
- There was a newly established follow up clinic which was consultant led. Patients with psychological or other rehabilitation issues were identified and the appropriate services were contacted locally to arrange additional support as needed.
- Staff used patient diaries for those who stayed in the unit on a longer-term basis. The diaries were given back to patients as part of the follow-up clinic after discharge and used to help patients make sense of their memories of the unit. Staff were exploring the best way to use the

Critical care

diaries, including looking at evidence to help direct them with the most appropriate content. Staff used a sample of 25 patient diaries from ITU to identify good practice and highlight areas for improvement.

- An end of life care champion nurse worked in HDU and liaised with the palliative care team when caring for patients who had reached the limit of their treatment.
- Staff were able to accommodate patient needs where this would reduce anxiety and improve recovery. For example, one patient was due to be discharged from HDU to a ward. They were claustrophobic but needed to use a lift to get to the new ward. To address this, staff secured a bed on a similar ward in the hospital on the ground floor, which meant they did not need to use a lift.
- Visiting hours for relatives in the HDU had been set as a result of feedback from patients. However, staff were flexible with this. One patient said their family had visited from overseas and staff had “gone out of their way” to facilitate their visits.
- Following feedback from relatives, staff introduced new resources to help communicate with patients who could not speak. This included whiteboards with magnetic letters that patients could move to spell out words and guidance for staff on communicating through written notes.
- Following feedback from relatives and visitors to ITU, a buzzer paging system was introduced. Visitors were given a pager which staff activated when it was appropriate for people to come back to the unit. This meant that visitors were not waiting around the unit for long periods of time.
- An ITU staff research project focused on patients with psychosis and how the differences in how medicine and the ITU environment could contribute to this. As a result, nurses used two-hourly intentional rounding to closely assess patients and ensure their condition was managed in a way that reduced the risk of psychosis.
- Patients and visitors had given feedback to HDU staff regarding noise in the unit from machines and call bells. To address this staff provided ear plugs to patients to support a better quality of sleep. Staff also purchased portable DVD players and radios for patients.

- The visitors’ room was small and the matron’s office was used to accommodate larger families if staff wished to address them privately.
- Staff had access to translators to assist with communication with patients who did not speak English.

Access and flow

- Bed occupancy for ITU was 97% between June 2015 and June 2016. The occupancy rate for HDU wards was 110% for the same period. This was above the average rate recommended by The Royal College of Anaesthetists (65-70%). This meant people were not always admitted as planned where there was no bed availability. Expansion plans were due to add six ITU beds in late 2016. There were also some delayed discharges. Staff told us the most common reason for a delayed discharge was a lack of capacity and flow in the hospital.
- In Quarter 4 of 2015 Harefield hospital cancelled 14 out of 306 elective surgical critical care bed bookings due to a lack of availability of post operative critical care beds.
- Critical care and surgical consultants planned elective admissions as part of a multidisciplinary team, including whether patients would be admitted to ITU or to recovery. Patients were reviewed by a consultant in critical care within 12 hours of admission. This was in line with the Guidelines for the Provision of Intensive Care Services 2015.
- Senior staff from critical care attended daily bed meetings to plan discharges. This was used to make the most of capacity in the hospital and to reduce discharge delays.
- Between October 2015 and March 2016 a total of 31 patients from critical care were transferred to a different ward between 10pm and 7am. This was against the Faculty of Intensive Care Medicine guidance which states that discharge from critical care should occur between 7am and 9:59pm. The discharges had been recorded as incidents and the incident data for critical care at Harefield revealed that the majority of the out of hours discharges were as a result of emergency admissions to the critical care unit.
- There were 452 delayed discharges in critical care between April 2014 and March 2015. Staff told us that they continue to experience delayed discharges due to a lack of beds elsewhere in the hospital.
- The critical care unit had not historically contributed to the intensive care national audit and research centre

Critical care

(ICNARC) programme. This meant that we were unable to compare the number of delayed discharges with other comparable units nationwide. We asked the Trust to provide us with data on the most recent North West London critical care network peer review to allow us to compare the number of delayed discharges with similar units nationwide. The Trust informed us that this data was not available as the peer review had not yet occurred.

- Incident report data received from the trust indicated bed capacity in critical care was a concern and out of hour discharges will continue to happen due to bed requirement for emergencies especially when critical care areas are full to capacity.
- Staff told us that there were readmissions to ITU and that these were generally due to the CCOT using the NEWS assessment on patients in HDU following discharge from ITU. If the NEWS assessment indicated a deterioration patients were often readmitted to the ITU. Data received from the Trust following the inspection shows that there were six readmissions to ITU from HDU between April 2016 and September 2016. One of the six readmissions was within 48 hours of the patient being discharged from ITU.
- On Fridays HDU anaesthetists and theatre managers reviewed all elective cases for the following week. This allowed them to plan and spread HDU and ITU cases across the week to use bed capacity to maximum. This improved flow, reduced cancellation rates, and ensured that all equipment needed would be available.

Learning from complaints and concerns

- The trust had a complaints policy which could be accessed via the intranet. Staff demonstrated appropriate knowledge and adherence to this.
- Between April 2015 and March 2016 critical care services received nine formal complaints from ITU, HDU and the HDUs on Maple and Acorn wards. Of the nine complaints, five were upheld, two were partially upheld and two were not upheld. Complaints were investigated and lessons learnt were used to change practice. For example, in December 2015 a relative of a patient in ITU complained that there were no facilities at the Harefield Hospital on Christmas and Boxing Day as the restaurant was closed. In response to this complaint, plans have already been made to make services available on Christmas and Boxing Day 2016.

- Learning from complaints was disseminated to staff through meetings with ward matrons and sisters, safety huddles, notice boards and the newsletter which came out every two weeks.

Are critical care services well-led?

Good



We rated well led as good because:

- Staff worked within robust and well-structured leadership and governance systems in which their feedback and contribution to drive and improve the delivery of high quality person-centred care was valued. Senior staff facilitated this within a working culture that rewarded good practice and provided opportunities for development.
- The strategy for the service was clear and staff knew their role in achieving this strategy. We saw copies of the trust strategy on walls in most staff rooms and offices. ITU and HDU staff had contributed to the vision and strategy for the service so that it met the needs of the trust but also reflected the unique working environment and challenges of critical care.
- Staff at all levels reported high levels of staff satisfaction in relation to working in critical care areas. All staff we spoke to were very positive about the leadership of the units and said they appreciated the flexible and supportive approach of managers and senior staff. For example, staff who had personal commitments or who wanted to take a university course were supported to achieve a positive work-life balance.
- Staff were proud of the hospital as a place to work and spoke highly of the friendly and inclusive culture. Senior staff valued engagement with staff development, which contributed to a growing track record of collaborative research projects. Such projects enabled staff to work together to better understand the needs of patients and relatives and represented an innovative approach to service development and improvement.
- The units actively sought feedback and constructive challenge from patients and their relatives to identify areas of unmet need and to help staff better understand the experiences of people.

Critical care

- Innovation was encouraged and celebrated. For example, critical care consultants had developed simulation training for extracorporeal membrane oxygenation (ECMO) as well other courses aimed at the multidisciplinary team and feedback from staff had been positive.

Leadership of service

- A divisional director for critical care worked across both the Royal Brompton and Harefield sites. ITU, HDU and Recovery wards had the same matron. Maple and Acorn HDUs were not under the same matron as ITU, HDU and Recovery; however, all the critical care wards (ITU, HDU, Recovery, Maple and Acorn) were under the remit of the same general manager, divisional director and lead nurse.
- The HDU had undergone a period of change in its leadership team. All of the staff we spoke with said the team had remained stable and nurses felt supported through the change. The critical care matron had previously worked on the HDU as a ward manager, which helped to continue positive working relationships.
- The matron completed a daily walk around of critical care areas. This enabled them to track patients, speak with staff and provide any leadership support needed.
- In the 18 months prior to our inspection, 51 new nurses had joined the critical care team. This presented a significant challenge to the leadership and education teams and therefore part of the short-term vision had been to establish a robust and coherent team. This had been achieved through consistently positive support and supervised development.
- Staff we spoke with were very complimentary of the leadership of critical care. We were told that leadership was visible and approachable.
- There was confidence that the needs of the service were represented outside critical care. The Harefield hospital risk lead was a critical care consultant.

Vision and strategy for this service

- Staff contributed to the vision and strategy of critical care services for their own units. They worked together to identify how critical care could meet the broader strategy of the trust and how their own work contributed to this.

- Staff in the intensive therapy unit (ITU) and the high dependency unit (HDU) included increased joint working as part of their future strategy. As part of this strategy they planned to recruit two extra consultants to allow flexibility in supporting the critical care unit at the Royal Brompton hospital site.
- A number of consultants had recently departed the critical care unit at the Royal Brompton site and the strategy took this into account.
- ITU staff worked together to establish a code of practice for patients, called 'We will always...' This included 10 core standards that patients could expect, such as staff washing their hands; respecting cultural needs; maintaining privacy and dignity and giving patients enough information to make decisions about their care.
- Staff in the HDU identified short-term goals on a monthly basis, in addition to their long-term strategy. For example, recent goals had been to trial new visiting hours and improve pressure ulcer prevention.
- Staff told us that there was joint working between critical care at Harefield Hospital and critical care unit at the Royal Brompton site. The plan is for there to be more joint working across the two sites, particularly in terms of education and training.
- We saw evidence of such joint working in relation to the ECMO service. Some consultants from Harefield Hospital spent their time between the Royal Brompton site and the Harefield site to enhance their knowledge and experience in ECMO.
- There were plans to increase ITU capacity by six beds. We were told that building would commence in the later part of 2016.

Governance, risk management and quality measurement

- The director of critical care worked across both the Harefield and Royal Brompton sites. A lead consultant, a general manager and a matron led the ITU, HDU and Recovery at Harefield. This contributed to a coherent and highly regarded leadership and risk management structure. The HDU for Acorn and the HDU for Maple ward were managed by different matrons and senior teams.
- There was a risk register for critical care which identified risks and ranked them according to likelihood and severity. There were four items on the risk register, all of which were ranked as low or very low risk. Risks were

Critical care

monitored regularly and reviewed. The risk register showed the initial rating of a risk, the current rating and the target rating. For example, the damage to the ITU floor was initially rated as being very low with a rating of four. At the time of our inspection the initial rating had been reviewed to low with a rating of three and the target rating was a score of two. The next review date was set for September 2016.

- Quality and safety meetings took place monthly and the risk register was discussed in this meeting. Cross site risks were also discussed.
- The critical care unit did not contribute to the intensive care national audit and research centre (ICNARC) programme. This meant the service was unable to benchmark patient outcomes against similar units nationwide. The trust were unable to provide us with the numbers of delayed discharges for Harefield critical care between April 2015 and April 2016.
- The trust trained staff in the duty of candour and levels of responsibility were related to job role. For example, doctors would normally discuss incidents or mistakes with patients and relatives and other clinical staff would be involved if appropriate.
- A series of staff meetings based on grade and role contributed to the overall governance structure. This included a monthly senior nurse meeting and a bi-monthly deputy sisters meeting. Team leaders had two days of protected time each month to catch up with their staff. This contributed to the cohesiveness of the teams we spoke with and observed..

Culture within the service

- There was a strong culture of openness and transparency. Staff felt comfortable reporting incidents and approaching senior staff where they felt they did not know how to do something. This meant they were supported in professional development and had opportunities to learn from reflection on their work. This was especially evident amongst newer members of staff who spoke warmly about the support, supervision and mentorship they received when they joined the hospital.
- All staff we spoke to told us that they felt valued and respected. Staff told us that when they voiced concerns or had new ideas senior staff were always willing to listen and take staff ideas into account in developing the service.

- Senior staff, the practice educator and practice facilitators facilitated an environment and culture in which achievement was rewarded and developing staff had unlimited support and guidance to build their confidence.
- Nurses were organised into teams, each with a team leader. Several staff told us they had been supported to work flexibly to achieve a better work-life balance as well as to pursue other interests, such as a college course. The matron came into ITU, HDU and recovery before the night shift team left for the day so she could see them and be available if they needed her. This was part of a broader culture in which teamwork and positive working relationships were visible and embedded.
- Staff at all levels described a good working environment. A new member of staff told us, "My first few months here have been amazing. Everyone is so supportive; the hierarchy works with us not against us. The matron is really visible, which I really like and makes everyone feel part of one team." A consultant told us the ITU and HDU worked well together and said overall the units formed, "an exceptional learning environment." Another consultant said, "This is an inclusive, highly respectful team. It's the most family-like place I have ever worked in."
- Senior critical care teams recognised the need to support staff so they could, in turn, provide the best care possible to patients. To address this they used a 'caring for our caregivers' programme that encouraged them to manage the welfare of their staff. This included a five-point commitment to how senior staff managed their teams, such as by inspiring staff to work beyond their expected limits and always listen to comments and concerns.
- Multidisciplinary nurses and a service manager had completed a research project into the working culture of critical care, specifically in relation to whether nurses felt courage to speak up for patient advocacy. This improved the confidence of clinical staff to constructively challenge when they felt alternative treatment options should be considered.

Public engagement

- Staff in the ITU and HDU actively sought feedback from patients, relatives and visitors. For example, through the

Critical care

use of a questionnaire and verbal feedback during follow-up clinics. This led to changes in the unit, such as the introduction of protected meal times. ITU staff had asked patients and relatives about piloting a policy of open visiting, without time restrictions. Senior staff used this feedback to decide not to trial this.

- A patient experience clinic was used to understand how patients remembered their time in ITU. For example, one patient returned and remembered the voice of a clinician they heard whilst being treated but had not seen their face. The senior team used this to emphasise the importance of positive communication when speaking around a patient's bedside.
- As part of a research project, nurses had produced a poster about caring for the relatives of patients in ITU. This included evidence-based guidance for staff such as encouraging relatives to help cream limbs, which they found helped to make relatives feel useful. This project also highlighted the need for honesty when in discussions about prognosis and treatment plans.
- Critical care staff had undertaken research that involved a combination of patient's, relatives' and staff feedback. This was in relation to the use of a trial patient profile document used on admission. Using existing evidence of similar strategies tools usually used for patients with dementia, staff produced an adapted tool that considered how to individualise care. For example, asking patients what they preferred to be called, such as a nickname or shortened name and asking them about their hobbies and interests. Feedback from staff and relatives was used to refine the tool and had been very positive. For example, one patient said "The nurse put my favourite radio station on and I was more aware of what time of day it was." A member of staff said, "A great innovation, families love them, a really great tool to feel closer to my patient."

Staff engagement

- There was a track record of staff engagement at all levels in critical care. For example, the senior teams in HDU and ITU had asked staff how they thought their work fit in to the trust's broader vision and strategy for the future. This was part of the appraisal process and staff told us they felt valued and involved as a result.
- Senior staff used the three stages of staff engagement as recommended by NHS England. These were 'involvement', 'advocacy' and 'motivation'. This meant engagement strategies were benchmarked against national best practice guidance.
- At the end of each shift in ITU and HDU, staff were encouraged to complete anonymous feedback on colour-coded cards using a 'traffic light' system. For example, a green card was used for positive feedback about the shift, an amber card for neutral feedback and a red card was used to suggest constructive improvements. 'Red' comments were displayed in a public area along with details of how senior staff had addressed this. For example, one member of staff had said they felt the number of junior staff allocated to the same shift had impacted their ability to support them and work efficiently. In response, senior staff planned staffing rotas to ensure a more even mix of experienced and junior staff. 'Green' comments frequently mentioned good team work and support from colleagues. Staff also used these to comment on positive relationships from the leadership team, including when the matron had bought staff ice creams during a challenging shift in a hot environment. In April 2016 and May 2016, in ITU 58% of responses were green, 27% were amber and 15% were red.
- Where a member of staff identified specialist or additional training they would like to take part in, practice facilitators supported this if the individual could prove how it would benefit their professional development and their unit. This included submitting a statement of intent and identifying objectives in their professional development plan. For example, one member of staff was in the process to secure training for the care of patients treated with bypass valve surgery. The senior team supported this and the member of staff said they felt their career progression was taken seriously.
- Senior staff produced a two weekly newsletter for critical care staff which kept staff updated on any changes in critical care practice. The newsletter also communicated to staff any learning coming out of incidents and complaints.

Critical care

- The critical care outreach team (CCOT) conducted a staff survey across the hospital. This was designed to improve the support provided by the team in responding to deteriorating patients as well as in their education role.
- Staff were clearly responsive to the needs of each other. For example, nurses expressed concern at keeping a patient on C-PAP when they were on an end of life care pathway. The consultant and the end of life care champion nurse had met with staff, acknowledged that treatment had appeared upsetting but explained why it was needed and how it helped the patient. Staff involved with this told us they had been reassured by the information and had felt their concerns and feelings had been taken seriously.

Innovation, improvement and sustainability

- There was a clear, sustained focus on promoting staff development, research and innovation. This was evident at all levels of critical care from research outputs we looked at and in our conversations. This was shared publically on display boards titled 'Celebrating Nursing Innovation' and included conference posters and

research reports. Recent work included a CCOT-led project to reduce acute kidney injury in thoracic surgical patients. A multidisciplinary team completed a project to review the follow-up screening tool use by staff after ITU or recovery discharge.

- The practice education team had an opportunistic approach to providing staff with new learning. For example, where patients were admitted with rare, unusual or complex conditions, nurses were able to observe treatment procedures.
- The nurse rotation programme included a monthly article written by a nurse that was published and displayed for colleagues to read. A senior nurse offered all staff on the programme opportunities to meet and socialise as a method to stimulate multidisciplinary learning and sharing of experience.
- Staff demonstrated a focus on continual improvement of the quality of care. For example, in the summer staff sometimes took ventilated patients outside as part of "sunlight therapy". This was possible due to wide access doors to secure outside space from some critical care areas and was only completed when a robust risk assessment was in place.

End of life care

Safe	Good	●
Effective	Good	●
Caring	Good	●
Responsive	Good	●
Well-led	Good	●
Overall	Good	●

Information about the service

End of life care (EOLC) relates to patients who have been identified as having entered the last 12 months of their life or less. It refers to care of patients in the final hours or days of their lives, and to the care of all those with a terminal illness that has become advanced, progressive and incurable.

Palliative care is a multidisciplinary approach to specialised medical care for people with serious illnesses, both cancer and other illnesses. It focuses on providing patients with relief from the symptoms, pain, physical and mental stress of a serious illness. The goal is to improve quality of life for both the patient and the family.

Palliative care at Harefield hospital is provided at by a specially trained team of doctors, nurses and others who work together with other health service staff to support people at the end of their lives.

The specialist palliative care team at the Harefield hospital is made up of two clinical nurse specialists, a 0.2 working time equivalent (WTE) consultant, junior doctors and other allied health professionals to provide care for patients.

There were 350 adult deaths on wards at Harefield hospital in the year April 2014 to April 2015. The majority (78.8%) of these deaths occur in the critical care environment, where patients are generally ventilated and sedated. There were 377 referrals to the specialist team in the same year.

Harefield Hospital does not have any dedicated hospital beds for patients who are dying. Patients in the last days or hours of life were cared for in a side room on the main

wards when possible. The specialist team works closely with the patient and those close to them, the hospital doctors, ward nurses and other allied health professionals in supporting the patient's needs. They also liaise with hospices and other community support agencies to facilitate rapid discharge to patients' preferred place of death.

During this inspection, we spoke with 46 members of staff including members of the specialist team, ward nurses, health care assistants, trainee doctors, consultants, allied health professionals, porters, the chaplain and the bereavement officer, who was part of the patient advice and liaison service (PALS). We spoke with four patients and one relative. We reviewed six care records and four do not attempt cardio pulmonary resuscitation (DNACPR) records. We observed staff interactions with patients and those close to them. During and prior to the inspection we requested a large amount of data in relation to the service which we also reviewed and considered when making our judgements.

We visited most of the medical and surgical wards, the transplant unit, the mortuary, the PALS and bereavement office, the chapel and multi-faith rooms and the room for relatives.

End of life care

Summary of findings

We rated this service as good because:

- There was an open and transparent culture across the trust, where staff felt comfortable to express their views and approach managers with their concerns. Learning from incidents and complaints were shared across the specialist team and the trust, now that data had been coded in such a way to allow this.
- The environment and equipment in both the hospital wards and the mortuary was suitable for purpose. Infection prevention control (IPC) measures were followed by staff from the mortuary, porters, specialist teams and whilst we observed care on the wards.
- Patient care records were completed with evidence that patients' needs were appropriately assessed and monitored. Staff clearly documented do not attempt cardio pulmonary resuscitation (DNACPR) decisions and ceilings of care. They considered different treatment options and showed clear involvement of patient and relatives in treatment decisions. Pain relief, symptom control and nutrition and hydration were well managed and individualised to each patient. The service recognised individuals with complex needs and tailored their care accordingly.
- There were enough specialist nurses on the palliative care team to enable them to see all patients on their caseload. Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as and when required.
- The specialist team had introduced EOLC champions that were based on all wards to assist, train and support ward staff with the care of patients at the end of life. Resource folders were accessible on all wards for staff to refer when they needed guidance or information on issues relating specifically to EOLC.
- A multidisciplinary team approach was evident both across the specialist team and across the hospital. Patients at the end of life were cared for compassionately and holistically, with input from psychology, chaplaincy, physiotherapists and other

allied health professionals (AHPs) as necessary. The needs of relatives were also considered and addressed by the wards, specialist team and dedicated bereavement service.

- A recently developed EOLC strategy aimed to ensure that the specialist team were able to support other staff even further in the event of death. A detailed educational strategy was in place and due to be rolled out to ensure staff across the trust felt confident with caring for patients at the end of life. Regular meetings and forums took place that addressed issues in EOLC with various stakeholders. This included a specific EOLC steering group that met quarterly to discuss any issues specific to EOLC.

However:

- There was a lack of consultant presence at Harefield hospital. There was currently only a 0.2 WTE consultant, who was employed through a service line agreement (SLA) with East and North Hertfordshire NHS Trust. The service had submitted a business case to the trust board for increased consultant cover but this was not yet in place.
- The trust had not fully rolled out a validated assessment tool to document care of patients at the end of life when the Liverpool Care Pathway was discontinued in 2013. The specialist team used the London Cancer Alliance (LCA) principles of care document, but resource files containing this document were not yet available in wards and staff knowledge in this area varied. This meant a lack of consistency and knowledge across wards regarding care of patients nearing end of life.
- Data collection for issues relating to EOLC was currently an issue, limiting the amount of audit activity that the specialist team could take part in and use to improve patient outcomes. The service recognised this as an issue and new data processes were being devised by the IT department to collect information linked to the specialist team's MDT proforma.
- The specialist team's core working hours were 8.30am to 5pm, Monday to Friday. This is contrary to national recommendations, stating that specialist palliative care should be available face-to-face, seven days per week.

End of life care

Are end of life care services safe?

Good



We rated safe as 'good' because:

- There was an open and transparent culture in regards to reporting incidents and learning was shared across the specialist team and trust.
- Infection prevention and control (IPC) measures ensured that the environment was clean and suitable for purpose.
- All equipment was fit for purpose and had been recently serviced.
- Patient care records and risk assessments were appropriate, thorough and complete.
- Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the paper patient records for easy access. They were completed by a consultant and recorded detailed discussion and reasoning for decisions.
- End of life care (EOLC) champions and practice educators on each ward helped to ensure that training and resources were available to general staff in supporting patients who were actively dying.
- Nursing staffing levels in the specialist team were sufficient for staff to perform their roles.

However:

- Despite a recent incident relating to the use of syringe drivers, 68% of ward nursing staff had been trained in this competency. Specific EOLC training had been planned but not rolled out to nursing staff on the wards at the date of our inspection.
- Not all members of the specialist team had completed their annual mandatory training.

There was only 0.2 WTE (working time equivalent) consultant cover at Harefield hospital at the time of our inspection.

Incidents

- Staff in the both the specialist team and on the wards were aware of trust wide systems to report and record safety incidents and near misses. All staff we spoke with were familiar with the electronic reporting system and how to navigate this. They were able to give examples of when they had used the system to report appropriate

incidents. The system had recently been adjusted to highlight any incidents relating to end of life care (EOLC). This enabled feedback and learning points from incidents to be shared with staff across the trust via email and team meetings. Incidents relating to EOLC were also routinely discussed in the EOLC steering group, monthly specialist team meetings and senior management meetings.

- The specialist nurses at Harefield hospital were aware of one recent incident relating to EOLC that had occurred in January 2016 at the Royal Brompton Hospital. This related to staff competence with the McKinley T34 syringe driver (a device to deliver pain relief medication via a needle or soft cannula under the skin) and a ward nurse not being aware of syringe driver policy or how to locate it. There was a delay in locating a member of staff who was able to find and start the syringe driver. This incident raised concerns relating to the competency of staff in using this device as none of the ward staff on shift had undergone any recent syringe driver training. In response to this incident, staff competency in relation to syringe drivers was added as a concern to the risk register and the need for further training was identified as a priority for both new and established staff, across both trust sites.
- Two previous incident reports had been completed due concerns over labelling placement on syringe drivers across Harefield Hospital. As a result, the roll out of the new syringe driver policy was delayed. The issue was resolved with research and discussion with those concerned. The new policy clearly showed photographs on how to position these labels correctly.

Duty of Candour

- Staff at all levels confirmed there was an expectation of openness when care and treatment did not go according to plan. They were aware of their responsibilities with regards to duty of candour. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. The trust had a lead for the duty of candour who was also the lead clinician for clinical risk.
- Staff were able to provide examples of situations when an incident had occurred, how they had informed the patient and their relatives of the incident, made an

End of life care

apology and explained what investigation and actions had resulted from this. The service introduced a yearly retraining system and checklists as the result of an incident.

Cleanliness, infection control and hygiene

- The trust had an infection prevention and control (IPC) policy and all staff received mandatory training relating to this. Each ward also had an IPC link nurse. Link nurses act as a link between the ward and the infection control team. Their role is to increase awareness of infection control issues and motivate staff to improve practice.
- We found the mortuary and associated areas to be visibly clean and tidy during our inspection. There was a separate operational policy in place to ensure infection control processes were followed in the mortuary and post mortem room. There was a very clear and descriptive policy for post mortem procedures, mainly detailing the infection control procedures, cleaning and disinfection procedures and how to deal with deceased patients. There were sharps bins and appropriate changing rooms with aprons and wellington boots available, as per policy. The mortuary technician, who was responsible for ensuring the entire area complied with IPC standards, emptied appropriate clinical waste bins daily. We saw records that indicated that the mortuary was cleaned every other day by domestic staff and fridges were deep cleaned every six months.
- Handwashing facilities and personal protective equipment (PPE) were both available in the mortuary if required. The mortuary technician, who was trained in decontamination procedures, was responsible for any IPC issues that occurred in the mortuary.
- Appropriate procedures were followed in the event of death to identify and protect staff from infectious disease. Staff adopted standard IPC precautions at all times and carried out thorough risk assessment prior to contact with the deceased. Death notification paperwork was completed by nursing and medical staff to evidence this, before a body could be removed from the place of death. Copies of these forms accompanied the body to the mortuary and the use of discrete labels to indicate infection was recommended where necessary. We saw evidence that these forms were appropriately filled out and used as stated in the corresponding policy.
- We saw clear records on site that indicated that all porters at Harefield hospital had undertaken training in

IPC and hand hygiene within the last year. Porters that we spoke with were aware of appropriate infection control measures to take in relation to deceased patients, such as the use of PPE when transferring deceased patients.

Environment and equipment

- The trust used T34 syringe drivers for delivering measured doses of pain medication. These conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia (pain relief medication delivered via a needle or soft cannula under the skin). The syringe drivers had in-date annual maintenance checks and/or corrective maintenance in line with the manufacturer's recommendations. The trust had amended the syringe driver policy due to a medical device alert highlighting the risks of prolonged exposure of the devices to direct sunlight.
- Ward staff obtained syringe drivers from the medical engineering department. There were no problems in accessing syringe drivers whenever patients needed them, as there were 50 syringe drivers on site, eight of which were used for palliative patients exclusively. Staff requested syringe drivers via a standardised form, according to policy. Stamped, addressed envelopes were provided to patients and their carers, so that syringe drivers could be returned to the hospital once the patient had finished using them.
- The mortuary had capacity for eight patients. Depending on the number of deaths at the hospital, they had the option to move deceased patients to a designated funeral directors, or alternative hospital, usually the Royal Brompton. The service informed relatives of this when a patient died and we were informed that this was routine practice. If a coroner needed to review the deceased, they could not be moved without permission and authorisation. An incident had recently occurred the hospital had incorrectly transferred a deceased patient to the Royal Brompton hospital out-of-hours whilst requiring examination by the coroner.
- There was an automated temperature measurement system, and a record of fridge temperatures was kept daily by the mortuary technician. The fridges were linked by alarm to the switchboard for temperature control and 24-hour servicing arrangements were in place in the event of there being a problem. In the event

End of life care

of problems occurring out of hours, clear escalation plans were in place. The records seen during our inspection showed that there had been no problems with the fridges since 2013.

- All equipment in the mortuary and post mortem room had been recently serviced and labelled to indicate the next review date.

Medicines

- The trust did not have a specialist pharmacist for palliative care but the team could access advice from specialist pharmacists in other specialist fields, such as pain management.
- If a patient required a syringe driver, an additional electronic or paper based chart was used to monitor the site and rate of infusion, as well as the battery and maintenance of the device. No patients were receiving medication via a syringe pump at the time of our inspection. Nursing staff had to undergo a syringe pump competency assessment prior to utilising these devices in practice. Practice educators carried out syringe driver training at the ward level. A recent audit showed 68% of nurses had been trained across the trust. Evidence of planned further local training for 80 staff was seen. The service was incorporating syringe driver training into nurse induction training for new staff due to concerns raised in staff competency in this area.
- At present, the trust was developing an in-house audit tool to review anticipatory prescribing to take into account the number of patients that died within the critical care setting. These patients were often ventilated and sedated, altering the nature of anticipatory prescribing. The team prescribed anticipatory medications for patients, including those discharged to their own home or a hospice, to manage pain and common symptoms, if required. This prevented delays in symptom and pain relief. The specialist team were usually involved when these medicines were prescribed.
- The trust did not currently audit the use of opioids in palliative care, contrary to NICE Quality Standard CG140.

Records

- Hospital staff used a mix of electronic and paper based patient records to record patients' needs and care plans, medical decision-making and reviews, and risk assessments. Where staff used paper-based notes, they were usually stored appropriately in the nursing office on the wards that we visited. When members of the

specialist team were involved in the treatment and care of patients at the end of life, they added an entry to the patient record that detailed the discussions and agreed changes to the care plan. Only medication charts were electronic as standard, although this was being addressed by the trust and a plan was in place to introduce a fully electronic records system.

- We looked at six sets of patients' records across three different wards. Information was concise and clear. Conversations with both the patient and family were well documented and detailed. All notes were dated, signed and followed the trust's note writing protocol.
- Do not attempt coronary pulmonary resuscitation (DNACPR) forms were located at the front of the paper patient records for easy access. We reviewed four DNACPR forms and all detailed full discussion with patients and their relatives. A consultant had signed all forms and all had appropriate reasons for the decision recorded on the form.
- Medical Certificate of Cause of Death (MCCD) records were seen during our inspection; all slips and counterfoils were completed and filled out. The deaths and deceased register was also completed in full. An additional folder stated the review stage of each deceased patient's case, details of where their property was held, and family contact information.

Safeguarding

- Staff demonstrated an awareness of adult safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff had access to the trust safeguarding policy on the intranet. Adult Safeguarding was part of the trust annual mandatory training and all staff in the specialist team were up to date. Staff at all levels knew who to contact if they wanted further advice as there was a named safeguarding lead for the trust.

Mandatory training

- Nursing staff with the specialist team were not up to date with all of their mandatory training, according to records provided by the department. Some staff within the specialist team had not completed their yearly revalidations for adult basic life support, moving and handling patients, medical gases, medicines management and information governance.
- Mandatory training was provided to the mortician, porters and ward staff as to how to maintain and protect

End of life care

dignity and respect of deceased patients and their possessions. The porters at the Harefield Hospital site had recently completed their mortuary training according to records held on site at the time of the inspection.

- Patient advice and liaison service (PALS) staff had completed their mandatory training. However, they felt that there was a gap in their training around the topic of providing emotional support. The staff said they were recruited because of their previous experience, skills and knowledge in counselling, but felt further education would have been helpful. The staff also had to learn their role during the handover process from the previous employees, as there was no official role specific training given.

Assessing and responding to patient risk

- The trust used a system known as 'SAFETY' twice daily within the wards. This consisted of a checklist that included the checking of patients in side rooms, those that were acutely ill or at risk of falls, those patients at end of life and any patients with psychological or cognitive issues. A check of the resuscitation trolley was also included. Ward staff were then able to update themselves of any changes that had occurred throughout the day, and ensure that everyone was aware of all potential issues, or known risks, that could arise.
- Staff had completed skin integrity assessments to evaluate patients' likelihood of developing pressure ulcers, which are more likely to occur at the end of life due to changes in the body. Patients were regularly repositioned and pressure-relieving aids were used where appropriate to mitigate this risk.
- Falls risk assessments were undertaken in patients with impaired mobility. Management plans involving physiotherapists and mobility aids were put into place.
- Nursing and health care assistant staff monitored all inpatients regularly and used an Early Warning Score (EWS) to identify patients who were deteriorating. Staff on the wards were aware they could access advice and request support from the specialist team if their patient had been identified as requiring palliative support. A 'triggers tool' was available to guide staff in deciding whether or not the patient was entering the last stages of life and should be referred to the team.
- The wards used an end of life symptom control chart that allowed ward staff to record certain observations

such as pain, and how this changed over a period of time. This was used in the last days of life to ensure the patient had all their needs met. Their observations were recorded at four hourly intervals and signed off by a registered nurse. If a score of three or above was recorded on the chart, this prompted an immediate referral to a doctor for assessment and review of the patient, and their symptom control.

Nursing staffing

- The specialist team had at the Harefield hospital had two whole time equivalent (WTE) clinical nurse specialists covering the inpatient wards on weekdays, between the hours of 8.30am and 5pm. There was also a lead nurse and a practice educator who worked across both sites. The nursing staff felt that they had enough staff at the present time and would only need an increase in staffing if required to move to seven day working.
- There were no statistics relating to bank or agency use available for the specialist team at Harefield hospital. The practice educator was able to assume a clinical role to cover any sickness or absence, if the need arose.
- Handovers took place every morning at 8.30am. These were comprehensive and focused on the full holistic needs of each patient, discussing their not only their condition and comorbidities but also their social situation, family and any other complex needs. The nursing team used the handover to plan their visits for the day and anticipate any possible discharges or new referrals.

Medical staffing

- There was a 0.2 WTE consultant at Harefield hospital, who was employed through a service level agreement (SLA) with East and North Hertfordshire NHS Trust. The service had submitted a business case to the trust board for increased consultant cover at Harefield hospital. This was currently out for tender, and staff hoped that additional consultant cover would be in place by October 2016.
- Out-of-hours cover was provided via a SLA with the local hospice. The direct contact telephone number for the hospice was available in all clinical areas, as well as with the switchboard operators. Any member of the specialist team or ward staff could use this number if they needed consultant support or advice. Details were taken by a triage nurse and passed on to the on-call

End of life care

palliative care medical consultant. Daily handover was given to the hospice to keep staff there up to date with any patient conditions and requirements that were anticipated.

Are end of life care services effective?

Good



We rated effective as 'good' because:

- Care and treatment was provided in line with appropriate national professional guidance.
- Care was delivered by a range of skilled staff who participated in annual appraisals and had access to further training as and when required. EOLC champions acted as a link between ward staff and the specialist teams to provide staff with further support and training in areas relating to EOLC.
- Pain relief, symptom control and nutrition and hydration were well managed and individualised to each patient.
- A multidisciplinary team approach was in effect both across the specialist team and with the wards and services they worked with.
- Consent and capacity were considered when patients were making decisions about their preferences at the end of life, as well as in relation to the retention of organs and tissue.
- The hospital scored higher than the national average in four out of five key performance indicators within the NCD audit. Evidence was provided to show that the Trust had identified areas for improvement and discussions that had taken place to address these concerns.

However;

- The trust had not fully rolled out a validated assessment tool to document care of patients at the end of life when the Liverpool Care Pathway was discontinued in 2013. The specialist team used the London Cancer Alliance (LCA) principles of care document, but resource files containing this document were not yet available in wards and staff knowledge in this area varied. This meant a lack of consistency and knowledge across wards regarding care of patients nearing end of life.

- Ward staff expressed the need for further training and supervision around how to support and care for dying patients. An educational plan has been drawn up but had not yet been fully rolled out.
- The specialist team's core working hours were 8.30am to 5pm, Monday to Friday. This is contrary to national recommendations, stating that specialist palliative care should be available face-to-face, seven days per week.

Evidence-based care and treatment

- Palliative care was managed in accordance with national guidelines, which formed the basis of trust policy. For example, the guidelines for symptom control were based on World Health Organisation (WHO) guidelines for management of pain.
- The trust had not yet developed or introduced specific paperwork in response to the independent review of the Liverpool Care Pathway and had no validated assessment tool for staff to utilise and document that care at the end of life was consistent. The specialist team used the London Cancer Alliance (LCA) principles of care document based on the five priorities of care (One Chance To Get It Right, 2014) to guide their end of life care (EOLC). Resource files containing this document were available in wards at Harefield hospital and staff knew where to locate these.

Pain relief

- Medical notes showed that the numeric rating scale (NRS) was commonly used to record pain scores regularly alongside physical observations. Appropriate actions were taken in relation to pain triggers to make patients more comfortable. Staff were encouraged to contact members of the specialist team for advice in complex cases. The wards used an EOLC symptom control chart that allowed ward staff to monitor changes in certain observations such as pain. A score of three or more prompted an immediate referral to a doctor for assessment and review of the patient, and their symptom control.
- The specialist team were very proactive with regard to pain management and early intervention. During the course of inspection, we attended different multidisciplinary team (MDT) meetings and handovers where pain management and symptom control of patients were discussed. There were a number of patients that were receiving treatments for control of multiple symptoms.

End of life care

- The specialist nurses worked closely with the dedicated pain management service, who offered advice and support to patients who were experiencing pain because of their treatment or illness. A specialist nurse from the pain management service attended the palliative care MDT and often visited patients jointly with the specialist team. They notified the team of any potential referrals and worked closely with the specialist consultant to care for complex patients. There was a good working relationship between the two departments, and they met every Friday afternoon to discuss any staff that may require further training or support, as well as other matters.
- The specialist nurses visited the wards regularly. They reviewed online drug charts and spoke to ward staff about whether patients' pain and symptoms were adequately controlled and managed. Background doses of pain medication were increased where necessary. We saw examples in the records of pain control managed with PRN (pro re nata or as required) pain relief.
- We saw evidence that the service strived to meet the needs of those suffering from symptoms in the dying phase of life or because of their illness. The specialist team encouraged the use and regular review of both PRN and regular medication in view of changing symptoms. Complementary therapies were also available to patients to help manage symptoms. Patient records showed that they were prescribed medication to help with difficulty breathing and nausea where appropriate. There had also recently been a trial into the use of handheld fans to manage breathlessness. The majority of patients had found this helpful and the team planned to purchase more fans for future use. Results from the FAMCARE survey of 15 bereaved relatives across the trust in September 2015 showed that 12 patients were satisfied with the speed and attention with which their loved ones' symptoms were addressed by staff.

Nutrition and hydration

- All patients were screened on admission to ensure they were not at risk of malnutrition. The MUST (malnutrition universal screening tool) was used to identify the risk level of each patient and this was documented in each set of notes we saw.
- Dieticians attended the weekly specialist multidisciplinary team (MDT) meeting and contributed to discussions regarding appropriate nutrition and

hydration at the end of life. The speech and language therapists worked closely with the dieticians to establish the food and liquid consistency a patient may require if a patient had difficulty swallowing. Assessments and advice from dieticians and therapists were seen in the notes we examined. For example, some patients were started on dietary supplements because of input from the dietetics team.

- Staff placed importance on ensuring that patients were adequately nourished and hydrated with regard to their individual care plan. This included transplant patients that required regular meals and snacks throughout the day and evenings (and they were given a facility to order food from 7am to 7pm every day), and also patients undergoing active treatments, and those at the end of life. For patients that were not eating at the end stage of life, the ward staff and dieticians ensured regular mouth care was carried out to ensure patient comfort and hydrated the patient via a syringe driver.
- Protected mealtimes were in force, to ensure patients felt comfortable and safe to be able to eat their meals without any interruptions. Nutrition and hydration needs were found within patient care plans, and where possible, the patient was included in the decision making process.

Patient outcomes

- The trust carried out some routine audits of the palliative care service, but were currently working on ways to improve data collection as the electronic system was not currently set up to effectively do so. It was recognised that this was key to improving patient outcomes and the trust planned to complete audits in areas such as anticipatory medication prescribing in future.
- In the 'End of Life Care Audit: Dying in Hospital' in 2016, Harefield hospital scored higher than the national average in four out of five key performance indicators (KPIs). In 15 cases included in the audit, the hospital recognised 87% of patients that were likely to die within the following few hours, or days. This was higher than the England average at 83%. Discussions with the patient or relative had occurred in 87% of cases, above the national average of 79%. Their needs had been considered in 67% of cases (56% nationally) and a holistic assessment and individual care plan were in

End of life care

place for 80% of these people (66% nationally). The only KPI lower than the national average (84%) was the number of patients that felt they had their concerns listened to (80%).

- The trust identified areas for improvement from this audit around documentation of assessment of the dying patient and formal education for all staff in EOLC. The trust also planned to submit data across both sites for the next national audit to provide more meaningful data. We saw minutes from the April 2016 EOLC steering group that indicated that changes in documentation were being discussed. A detailed education plan had been drawn up that indicated how staff would be trained around specific EOLC topics such as advanced care planning, earlier identification and care of the dying patient.
- Patients receiving palliative and end of life care were cared for on the wards, with advice and support from members of the specialist team. There were 377 referrals to the specialist team between April 2014 and April 2015. Patients were reviewed within 24 hours of referral or more urgently if clinically indicated; 77% of patients were seen by the team within 24 hours of referral between January and March 2016.
- Any member of staff in the hospital could refer a patient to the specialist team. There was a 'triggers tool' available to ward staff to help them identify when referral may be necessary. This was done either via bleep, during ward visits or in the course of MDT meetings. Referring staff were encouraged to document the referral in the patient's notes and outline the patient's current clinical problems and reasons for the referral. The referral was discussed with the patient and medical permission was sought from the consultant responsible for the patient's care. The specialist team had a list of patients to be aware of that had not yet reached the threshold for referral.

Competent staff

- The specialist team was made up of competent and trained staff. They had opportunities to undertake personal development opportunities to enhance their skills and were able to give examples of further study days they had completed. The trust were actively supporting the nursing staff throughout the Nursing and Midwifery Council (NMC) revalidation process.
- The doctors and nurses we spoke with in the specialist team all reported receiving annual appraisals which

looked at their development needs and set achievable and realistic targets to measure progress. At the time of our visit, all appraisals had been completed except for one, which was scheduled to take place by the end of June 2016.

- The specialist nurses confirmed that they attended monthly clinical supervision sessions and could request more support as and when required. They worked closely with the psychology department to access support where needed. The team were very supportive of each other and did discuss difficult cases both for training, support and reassurance, and to help each other emotionally. This was discussed across both sites at the team webinar that took place every Monday. The specialist team also had the option to attend counselling appointments with occupational health, if they felt that they needed to have further support.
- The trust was not able to confirm revalidation of the specialist care team consultant for the Harefield hospital site at the time of our inspection.
- There were practice educators on each ward who were responsible for ensuring that staff had sufficient knowledge and skills to undertake their roles safely. Some micro training sessions had been given on subjects relating to end of life care (EOLC), which staff reported they had found useful. We saw one such session taking place on the safe use of syringe drivers during the course of our inspection. The specialist nurses also gave one-off training sessions to staff where needs were identified. All wards at Harefield hospital had recently introduced a nominated EOLC champion, who took the lead in supporting the education of ward staff in areas specific to EOLC. The champions supported good practice by maintaining up to date palliative care resource folders on each ward, supporting other staff in the care of dying patients and providing a strong link to the specialist team where required.
- Although there had been some in-house training days on subjects relating to EOLC and advanced communication techniques, there was no formal education programme in place for staff at the time of inspection. Most staff felt they could identify patients in the last stages of life and could describe what steps to take in this event, but welcomed the idea of further training in this area.
- The trust recognised that education in EOLC was a priority and had drafted a detailed education and

End of life care

training strategy to reflect this. Training on issues relating to EOLC were planned to be part of the induction for new staff as well as incorporated into annual mandatory training sessions and study days throughout the year. The implementation of this programme was discussed in the last EOLC steering group in April 2016.

- Ward nurses, health care assistants and therapists generally indicated that they felt knowledgeable in terms of supporting patients at the end of their lives. They were able to discuss how to care for a patient in their dying phase in terms of physical health and family support, for example. The staff were supported by practice educators and EOLC champions, who identified training needs and kept a resource file relating to EOLC up-to-date with current policies and practice guidance. Staff we spoke to on the wards knew where to locate this file.
- Within Acorn and Oak ward, there were three EOLC ward champions. They had been in post for two months, and had each attended an EOLC study day. The EOLC champions then shared this knowledge with other ward staff. At the time of our inspection, the champions were about to pass on the syringe driver update training they had received to new and existing staff.

Multidisciplinary working

- There was good attendance at the weekly site-specific multidisciplinary team (MDT) specialist palliative care meetings. One or more specialist nurses attended every meeting along with one of the palliative care consultants and registrars. The chaplaincy team also attended every week, with professionals such as physiotherapists, dieticians, pharmacists, social workers, psychologists and occupational therapists contributing where appropriate. We observed one such meeting and discussion of each of the patients was holistic and sensitive. There was clear joint working where each member of the MDT was able to challenge and request further information as necessary. A member of administrative support staff typed up the minutes from the MDT within 24 to 48 hours and these were available electronically on all wards.
- The team planned to further improve their MDT meetings by the introduction of a structured proforma. This had been successfully piloted at the Royal

Brompton hospital, to ensure that specific areas of care were covered for each patient and that each professional had a chance to offer their input. This had not yet been introduced at the time of our inspection.

- The specialist team also held a Monday meeting via video link to discuss recent cases, any training and to share good practice. The specialist team also facilitated cross-site bi-monthly meetings of the specialist team for the same purpose.
- A member of the specialist team aimed to attend other MDT ward and speciality meetings, especially in departments where patients were likely to be identified as requiring palliative care. For example, the hospital had developed a TEC (Transplant enhanced care scheme) MDT referral scheme and form. The specialist team worked closely with anyone requiring a transplant throughout the process and facilitated difficult conversations around the suitability of a transplant, for example. Regular joint meetings were also held with the pain management team.
- We accompanied a specialist nurse to the wards and saw her supporting the work of nursing staff in a constructive and practical way to enhance the care of dying patients. All the staff we spoke with knew the team and said they were readily accessible to give advice and support on EOLC. Senior nurses and doctors were aware of the referral process to the specialist team.
- The care records that we examined confirmed active involvement from health professionals of all disciplines where appropriate, including appropriate referrals to the specialist team. The complex discharge coordinator attended morning bed management meetings and ward multidisciplinary team meetings to identify patients requiring rapid discharges.
- There were service level agreements (SLA) held by the by the Pathology Services Manager to transfer bodies from Harefield hospital to a designated local undertaker, should they require post mortem by a coroner.

Seven-day services

- The specialist team's core working hours were 8.30am to 5pm, Monday to Friday. Out-of-hours cover was provided via a SLA by telephone advice from the local hospice's palliative care consultant on call. Any member of the specialist team or ward staff could call the switchboard and access support or advice, or an update on any actions taken out of hours. Ward staff confirmed that they felt comfortable to do so.

End of life care

- These arrangements were contrary to recommendations made by the 'End of Life Care Audit: Dying in Hospital' in 2016, which specified that face-to-face access to specialist palliative care should be available between the hours of 9am and 5pm, seven days a week. However, only 37% of sites were achieving this nationally. The service were looking at ways to expand their face-to-face contact hours but the remote location of the hospital made this more difficult.
- The hospital was one of the early adopter sites as part of the 'National 7 Day Services programme'. The scheme suggested that patients who were classed as emergency, or urgent, were required to be seen by a consultant within 14 hours of admission. An audit of Harefield hospital showed that this happened in 94% of cases.
- The chaplaincy service was available every day of the year, 24 hours a day. The team had arrangements with local faith leaders to provide an on-call out-of-hours service.
- There were clear policy and procedures relating to autopsy examinations and the subsequent retention of organs, to ensure that the trust was compliant with the Human Tissue Act (2004). A booklet entitled, 'The Post Mortem Examination: Information for Relatives' was produced for relatives of deceased patients who required a post mortem. The booklet explained the procedure in appropriate detail and included a form of consent that had to be signed by the relatives. Only the Bereavement Service team were trained to take consent for post mortems.
- A small survey of 10 patients who had received care from the specialist team was completed in April 2016, in which 90% of respondents agreed that their consent had been sought before any procedures or examinations took place.
- Staff undertook Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training. There was a policy on the intranet to support staff when considering MCA and DoLS. We saw evidence of two separate capacity assessments in the patient records. These mental capacity assessments were carried out by the psychology or occupational therapy department. There was a section relating to mental capacity on each do not attempt cardio pulmonary resuscitation (DNACPR) form, which was filled out by the doctor completing it in all four forms we looked at.
- An audit of 119 DNACPR forms was completed between January and December 2015. The majority (69%) of these forms were fully complete, but some issues were noted. Although all forms had an appropriate rationale documented and had been signed or countersigned by a consultant, there was a lack of information relating to discussions with the patient (not detailed in 72% of cases) and family (not documented on 49% of forms) were found. However, where discussion with the patient was not possible, 100% of forms documented why this discussion could not take place. Documentation of why family discussions did not take place only occurred in 40% of cases, which was recognised as requiring improvement. Further training and discussion around DNACPR forms has been planned because of this audit, with shared responsibility between the resuscitation department and the specialist palliative team. Spot checks and walk rounds by the resuscitation team were also planned to improve compliance.

Access to information

- Each ward had a palliative care resource folder for staff to refer to when required. It contained practical information such as how to obtain a death certificate, processes to follow on rapid discharge and how to support bereaved relatives. All staff were aware of these files and where they were kept. However, there was no clear record kept to indicate which members of staff had read the folder and no single person named as responsible for refilling the leaflets within the resource folder, once they had been used or given out. There was further information available to staff on the bereavement portal on the trust's intranet site, of which ward staff we spoke with were aware.
- A representative from the electronic multi agency care plan recording system was due to attend the next EOLC steering group. This was an electronic system developed to give patients an opportunity to create a personalised urgent care plan to express their wishes and preferences in relation to how and where they are treated and cared for. The addition of the database was identified as a specific step in phase two of the trust EOLC strategy.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

End of life care

Are end of life care services caring?

Good



We rated caring as 'good' because:

- Patients were cared for in a caring and compassionate manner by both ward staff and members of the specialist team.
- Patients' privacy and dignity was maintained throughout their hospital stay.
- Staff ensured that patients and their families were informed about their care and were fully involved in any treatment decisions.
- Psychological support for patients was well considered, easily accessible and timely.
- The chaplaincy team offered comprehensive spiritual support to those at the end of their lives.
- The specialist team had introduced memory boxes and overnight bags to support patients and their families at the end of life, making their final days and hours memorable and less stressful.

However;

There was only a small number of patients and relatives that took part in trust surveys limiting the feedback and improvements that could be made.

Compassionate care

- Staff we spoke with acknowledged the importance of patients' privacy and dignity; they made use of the day room and side rooms off the main ward to have sensitive or private conversations with patients and their relatives. If patients were bedbound they would draw the curtains and keep their voices down to ensure privacy. Patients told us they were happy with how their privacy and dignity were respected by staff.
- Patients we spoke with were consistently positive about the care they had received. They said the staff were "very good" and the care they received was "brilliant". One of the patients we observed was very drowsy. However, the nurse still spoke to the patient, introduced themselves and explained what they were doing. The patient later told us that they had "no complaints" in regards to ward staff or members of the specialist team.
- Staff treated patients with compassion and respect. We saw and heard from staff about examples of

compassionate care. For instance, staff made or arranged birthday and wedding cakes for palliative patients and arranged for their pets to visit them on the ward. During our inspection, we observed a patient watching a football match on television on the ward. The staff had provided this television specifically for this purpose.

- The specialist team at Harefield hospital had introduced memory boxes for EOLC patients. Those who died within hospital with young children were able to produce handprints and other keepsakes to place within the boxes so that relatives had a keepsake and memory of their loved one to take away from the hospital. Staff within the Critical Care Unit (CCU) were trained by the SPCT to be able to take hand prints of patients with their relatives so that this was still possible outside of the SPCT working hours. The CCU also had their own set of paints and paper provided by the SPCT for this purpose.
- The team had also introduced 'Betty bags', which were named after a volunteer at the hospital. These contained overnight essentials such as a toothbrush, soap, combs, and flannels, so that if a patient or relative had an unexpected stay within the hospital, they didn't need to go out to buy essentials. This aimed to reduce the stress and worry experienced by patients or their relatives.
- A small survey of 10 patients who had received care from the specialist team was completed in April 2016. The results were largely positive, with 9 of the respondents agreeing that they would recommend the service to friends, and all 10 patients agreeing that they had been treated with privacy and dignity at all times. Most (eight out of 10 patients) rated the overall care received from the specialist team as either 'excellent' or 'very good'. These findings are supported by the FAMCARE survey from September, where a further 15 bereaved relatives were surveyed. Most relatives (14) were 'very satisfied' or 'satisfied' with the level of comfort staff provided their loved one and 13 agreed they had been treated with a high level of dignity. Specialist palliative care input had been positive in regards to practical assistance, response to changes in care needs and management of symptoms throughout the final phase of life. Although both of these surveys used small sample sizes, they were reflected by the findings of our inspection process.

End of life care

Understanding and involvement of patients and those close to them

- Patients and relatives were involved in the planning of their care and they felt care plans were explained well. For example, we observed a transplant assessment take place. The specialist nurse introduced herself and explained her role in supporting the patient and their family pre and post-operatively. During assessment, the patient described how they felt breathless. The specialist nurse discussed different treatment options with the patient, such as the use of a hand held fan, certain exercises or appropriate medication. A hand held fan and leaflet explaining the exercises they could do to alleviate breathlessness were given to the patient. The specialist nurse also spoke frankly about the possibility of there not being an organ available for a transplant. The patient was encouraged to consider making an advanced care plan (ACP) and drafting a will. They were given details of a day hospice they could attend to meet other people in similar situations to access peer support.
- During our inspection we spoke to a patient that had recently had a lung transplant. The specialist team had shared their care jointly with the transplant team. The patient reported that they and their family were cared for and involved at all stages of their treatment. They felt well informed in regards to their prognosis, possible limitations in regards to their lifestyle and their medications.
- Relatives could participate in the care of patients when this was appropriate. For instance, a nurse told us about a time that they arranged for family members of a deceased Muslim patient to help with washing the body after death.
- Results from the local survey of 10 patients in April 2016 indicated that 7 patients had received written or printed information about their condition and that 8 patients believed this to be the right amount of information. A further 9 felt that the doctor and specialist nurses listened to their concerns, answered questions and 8 patients felt they fully involved them in their care. Results from the FAMCARE survey of 15 bereaved relatives in September 2015 reflected this, rating explanations for condition and likely prognosis highly (13 patients) as well as availability to the family (12

patients) . A further 12 patients valued the emotional support that the team provided to the family and 13 patients were 'satisfied' or 'very satisfied' with the way that the family were involved in care decisions.

- The hospital consultants were always available to meet with all relatives that had lost someone close to them at the hospital, approximately six to eight weeks after death to discuss the patient and their treatment or any concerns. The bereavement services officer was a central point of contact for all correspondence and for the relatives. They attended all meetings with the relatives regarding the deceased patient.

Emotional support

- Staff had a good understanding of the emotional issues palliative patients could face and described how they might give extra support to the most vulnerable patients, such as those with no family. We observed a member of the specialist team providing caring and sensitive emotional support and advice to a patient's close family member.
- The trust funded MacMillan nurses on the surgical thoracic team who supported patients living with lung cancer and other cancers. Patients are met at their first outpatients department appointment and are then supported emotionally at each stage of their care pathway, including pre and post-operative support. When patients were discharged from Harefield hospital, on-going support was provided by MacMillan community care nurses and local community nursing teams.
- One of the patients that we spoke to during the inspection was very clear that they felt the support that they had received from the specialist team was "second to none". The patient was given a 24-hour hotline number to call once discharged should they have any concerns. This phone line went straight through to the nurses. The patient stated that they had used the telephone line on a few occasions and found this useful and reassuring.
- Staff we spoke with described how they would manage difficult or sensitive conversations with relatives including making use of private rooms and ensuring appropriate clinicians were present to answer questions. The MacMillan nurses we spoke with told us that doctors knew that they should never give a patient

End of life care

bad news without them being present to provide the patients with emotional support. They told us that it was very rare for a doctor to give bad news without a MacMillan nurse present.

- Emotional support for patients was provided by the clinical psychology service, which was made up of psychiatric nurses and a lead consultant psychiatrist. The trust held a service level agreement (SLA) with another Trust [NW1] to provide this adult psychological service. An additional consultant psychiatrist was employed by the trust to head the liaison psychiatry service, which worked alongside clinical psychology to provide care for inpatients. Psychological support was discussed routinely in MDT meetings and handovers. A psychiatric nurse attended the weekly specialist palliative care meeting. There were no reported issues with waiting times after referral to the service.
- Patients considering transplant surgery were given a full day of counselling prior to being added to the transplant list. The counselling addressed any concerns the patient might have and helped them to fully understand the positives and negatives of the intervention. The aim was to fully prepare the patient for any possibility, including the fact that there may not be a suitable organ for transplantation.
- The SPCT was present at every meeting a transplant patient attended. They were introduced at the very first meeting and were integral to the patients care. The SPCT were part of all the meetings so as to make it natural and helpful, rather than a negative experience at a later date if the treatment did not go to plan.
- The hospital has a full-time Anglican chaplain who is supported by a volunteer team. The chaplain visited the high dependency unit (HDU), intensive care unit (ITU) and most of the wards every day to identify patients and families who needed support. There is also a visiting Catholic priest and Muslim Imam and other denominations were also available on an on-call basis. The chaplaincy service could arrange weddings, blessings, baptisms and confirmations on the ward. The team also arranged to visit patients that did not have anyone to visit them or were lonely.
- The patient advice and liaison service (PALS) team trained nurses to provide emotional support to families viewing deceased relatives in the mortuary.

Good



We rated responsive as 'good' because:

- The newly developed EOLC strategy aimed to ensure that services were designed appropriately to meet the needs of local people and the wider population.
- The needs of individuals with differing complex needs were well considered and largely met by the service.
- A dedicated bereavement service offered relatives support and advice to relatives when a patient had died in hospital.
- Staff were aware of the processes to support rapid discharge and a dedicated complex discharge team helped to facilitate this where possible.

However:

- At the time of our inspection, there was no flagging system for patients with learning difficulties or dementia on the electronic records system.
- The trust did not currently collect data or audit how many people died in their preferred place of death (PPD).
- Complaints data relating to EOLC had only recently been coded to allow it to be separated from other departmental complaints, limiting the amount of discussion and learning that could take place in the specialist team in this area.

Service planning and delivery to meet the needs of local people

- The trust End of Life Care (EOLC) Strategy was recently developed to reflect the National End of Life Strategy and incorporated national guidance to form its objectives over the course of the next five years (2016 – 2020). The strategy was drafted and revised to take into account various stakeholders, such as the executive board, board of governors, staff, patients, other local providers and Hillingdon Clinical Commissioning Group (CCG). However, Harefield hospital takes patients from a range of CCGs and geographical areas due to the specialist nature of the trust. An EOLC steering group was set up in December 2015 to monitor progress against key goals and outcomes specified in the strategic action plan.

Are end of life care services responsive?

End of life care

- There were no designated EOLC beds at the Harefield hospital. Ward staff moved patients at the end of life to side rooms whenever possible to provide privacy with their family and friends. A fold-up bed was provided for relatives to enable them to stay close by the patient if required. Food was provided for the relatives that had to stay at the hospital with the patient and there was no charge for their parking. There was accommodation within the hospital that relatives could pay to use, if they needed to stay with the patient on a long-term basis.

Meeting people's individual needs

- Advance care planning (ACP) varied across the trust. There was currently no formal validated tool to support the introduction of this but it was recognised as a requirement in the EOLC strategy (phase two). A representative from the electronic multi agency care plan recording system planned to attend the next EOLC steering group to discuss the benefits of rolling this system out across the trust. This was an electronic system developed to give patients an opportunity to create a personalised urgent care plan to express their wishes and preferences in relation to how and where they are treated and cared for.
- The chaplaincy team provided spiritual support for different faiths. The team represented a variety of faith traditions (Church of England, Church of Scotland, Catholic, and Muslim), and were also supported by six pastoral volunteers and an out of hours on-call service. The chaplaincy team fostered an extensive network of connections with faith leaders from other religious traditions who visited patients of other religions if required. They were generally able to be at the hospital within an hour of notification. The service did not currently collect data relating to the number of people of different faiths they visited but reported no issues with providing appropriate spiritual care to patients. The chaplain gave an example of multi-faith assistance provided, where a Hindu patient had two visits from a clergyman from a local temple (guduwara) during their hospital stay.
- The chaplaincy department produced and distributed a document called 'prayers for the very sick' and also produced a leaflet for staff regarding religious and spiritual customs and procedures for different faiths. Blue slips were placed in patient files so that the chaplaincy team were able to monitor patients' progress.
- The hospital chapel did have some Christian symbolism but welcomed people of all or no faiths. There was a separate small multi-faith prayer room, separated by screens so men and women could use it at same time. Headscarves and prayer mats were available. The chapel and separate Muslim prayer room were open day and night for prayer or quiet reflection. However, the multi-faith room was a little tired in its decoration and there was a loud ventilation system that was just outside the window.
- Although the viewing room attached to the body store was neutral in decoration, holy books and prayer books of different faiths were available for families to use on request. Trust policy stated that those responsible for the care and storage of the body should take into account various religious or cultural practices such as involvement in laying out the body, night vigils or providing 'mourners' to sit with the deceased. In such cases, mortuary staff were instructed to make every effort to accommodate such request within security and out-of-hours constraints. Arrangements for release of bodies to funeral directors that needed to be made out of normal working hours (for example, Orthodox Jewish or Muslim burials) were co-ordinated by the Duty Senior Nurse.
- As part of a specialist trust, Harefield hospital treated patients from all over the country and even internationally. The trust's three largest ethnic minority patient groups at the time of inspection were Indian (7.85%), Pakistani (2.87%) and Other Asian (2.96%). Staff were aware of how to access both telephone interpreting and face-to-face interpreting services, which were requested through a referral form sent via email. We saw evidence in a care record that indicated that an interpreter had been used to discuss treatment options with a patient. We were told that staff try not use families as interpreters as a rule. In urgent or rare situations, staff would request the help of other professionals in the hospital with the required language skills. The patient advice and liaison service (PALS) held electronic copies of all patient information leaflets that could be translated into other languages as requested. Braille or easy read format leaflets were also available on request.
- Patients gave positive feedback about the range and choice of food available. Within the menu there were many options to cater for those with different nutritional requirements. This ranged from high protein and energy

End of life care

foods through to soft fork, mashable and pureed food. Different menu items catered for those with food allergies and provided halal, kosher, vegetarian and vegan options. For those patients that had a nasogastric tube that missed the taste of food, a system called 'taste for comfort' was used to enable the patient to safely feel the texture and flavour of food without ingesting it. Dieticians worked closely with the kitchen staff to produce the menu and gave feedback to ensure the food was of a high standard and met all patient needs. Long-term patients were able to request additional items from the kitchen to vary their diet and were given vouchers for the hospital restaurant.

- A dementia champion system had recently been launched at the trust. Patients with memory issues were identified on admission and referred to their GP who then referred the patient on to a memory clinic. Patients living with dementia were offered 1:1 nursing care and family members and carers were encouraged to be involved in their care as possible. Red trays at meal times were used to alert nursing staff the patient may require extra help and finger food was available for these patients. The dementia status of patients was currently written in the patient notes. We were told these patients would be flagged on the electronic system in the future, which was currently being restructured.
- There was currently no lead nurse responsible for patients with learning difficulties due to staff sickness. At the time of inspection, there was no way for patients with learning difficulties to be flagged on the electronic system, although implementation of this was planned. The complex discharge team and occupational therapy department were available to advise staff on caring for patients living with learning disabilities. Auditing of their care had been agreed with the clinical audit team. However, this data was not available during the course of our inspection.
- Nurses we spoke with gave examples of where they had provided additional support to a patient living with a learning disability. For example the patients support worker was encouraged to come into the hospital and take pictures of the hospital ward and treatment areas. These pictures were then turned into an 'easy read' storybook which was used to explain the treatment process to the patient. The hospital also allowed the support worker and the patient's family to stay with them on the ward during their stay.

- Emergency psychiatric support was provided by the liaison psychiatry service. The department worked alongside the clinical psychology service to provide support to patients experiencing mental health difficulties. There were no reported issues with the service and staff found it easy to access, with no waiting times from time of referral.
- Ward staff gave relatives a locally produced bereavement pack which included information which covered all the practical tasks following a death in the hospital. There was advice and a checklist guide on registering a death, viewing and funeral arrangements and where to get extra information and support. Staff in the bereavement service were recruited from appropriate backgrounds to provide emotional support but still felt that they could receive further training. In the pack given to bereaved relatives, there was a leaflet entitled "Bereavement support" which signposted some other external agencies that could be accessed for emotional support. It was also noted by the specialist team that a lot of their work involved supporting relatives due to the high number of deaths occurring in critical care environments, where patients could often be sedated or ventilated.

Access and flow

- The trust did not currently audit the number of patients dying in their preferred location as the electronic system was not currently set up to collect data in this way. The service recognised this as an issue and new data processes were being devised by the IT department to collect information linked to the specialist team's MDT proforma. As many patients (78.8%) died unexpectedly in the critical care environment following complex surgery/treatments, there was no option for them to be transferred elsewhere due to the level of care, treatment, life support and medical equipment they required. The critical care teams were now collecting this information, and an audit was planned later in the year.
- Staff we spoke to were aware of processes relating to rapid discharge to enable patients to die at home or in a hospice. Once a patient's preferred place of death (PPD) was confirmed and a care plan and package had been agreed, this could usually be achieved within 24 hours. The hospital had a complex discharge team to coordinate this process who liaised with the specialist team, relevant hospital professionals and primary care

End of life care

services and agreed a plan of care. The complex discharge team was made up of many different clinicians, such as occupational therapists, dieticians, nurses, doctors, chaplains, speech and language therapists and welfare and benefits advisors. The team worked together to assess the needs of the patient. The patient and the family were involved throughout the process to ensure all needs were met, if possible and practicable.

- The complex discharge coordinator attended morning bed management meetings and ward multidisciplinary team (MDT) meetings to identify patients requiring rapid discharges. The trust had its own transport system that enabled the patient to be taken to their preferred place and a person of the patient's choice was able to travel with them. The trust had a service level agreement (SLA) with ambulance transport providers to facilitate rapid discharge. When a patient was discharged to their preferred place of dying, hospital staff gave information to ambulance crews about where to take the person if they died while being transferred. The do not attempt cardiopulmonary resuscitation (DNACPR) form was sent with the patient on discharge to their home or preferred hospice and could be used until a new form was put in place by their GP or doctor taking over their care.
- Ward and cancer patients were able to be sent home with assistance from the complex discharge team. In patient records that we examined, ceilings of care and the patients' PPD had been discussed and clearly documented. Rapid discharge was a challenge for the trust as they had to liaise with many different care providers nationally, and each borough and county had different processes and speeds at which care and equipment could be arranged. The team were able to discharge patients very quickly, as long as the counties that were receiving the patients were responsive, and had processes within the community to provide equipment and care, as required by the patients and their carers. There was a rapid discharge checklist in place to ensure all the relevant care, documentation, equipment, medication, transport was in place, and ready for the patient within their chosen place of care. Patients were also followed up once in the community to ensure the correct care, equipment and medication were provided.
- The administrative arrangements relating to death, including liaising with funeral directors, was undertaken by the bereavement office. The bereavement officer

liaised with bereaved families to facilitate the removal of bodies from the body stores within a timely period. We were told that this usually occurred within five days if no referral to the coroner was necessary. For those needing to deal with a death out of hours, paperwork was stored on the Bereavement Portal on the trust intranet or in the PALS office. There was clear guidance relating what to do in this case, although we were informed that most death certificates were not issued over the weekend unless in exceptional circumstances.

- Relatives and friends were able to view a body in a room attached to the body store. The public entrance to this area opened onto a small, but comfortable seating area, which led to the viewing room. A member of nursing staff from the ward where the patient died would escort the family to the viewing room and then handover care to the mortuary technician. The mortuary technician took care in preparing the body for viewing. They were able to describe this process and make relatives aware of any issues that may make viewing the body at the funeral parlour more appropriate.

Learning from complaints and concerns

- There were leaflets throughout each ward and department detailing how to access PALS and make a formal complaint, although none of the patients we spoke to had cause to do so. All new staff were given PALS training during their induction to the trust, and encouraged to try to resolve any complaint that was raised with them, directly and swiftly. If a complaint was classified as formal, the investigating manager telephoned the patient to get a clear understanding of the complaint, what was the result that the patient had hoped for, and to talk them through the complaints process. They would also try to encourage the patient to resolve the complaint informally, if it was considered appropriate.
- On the wards, the Band 6 and 7 nurses were able to deal with informal complaints at ward level. An example was given to us during the inspection as to how a complaint was resolved satisfactorily at ward level and, therefore, the complaint did not need to be escalated or formalised.
- Data provided by the trust indicated that there had been no complaints in the last year relating to EOLC. However, the specialist team explained that the system had only recently been coded to allow complaints specifically to EOLC to be separated from other departmental

End of life care

complaints. Complaints were discussed in the EOLC steering group, including one in April 2016 that related to an EOLC patient being discharged home to Dorset. This case was not known to the specialist team members present and so further information was requested from PALS to enable discussion and learning points to be shared.

- The complex discharge team and occupational therapists (OT) described a recent complaint relating to a patient that was discharged home without a full OT assessment as they had not been referred to the service. This led to a formal complaint being raised by the patient's relative. Learning took place as a result of this and it was agreed by the hospital that if there was any doubt as to whether a patient should be referred for assessment, they would be. The OT team would then decide if they needed to pursue the referral, based on initial assessment of the patient.
- Learning from local complaints was shared across the organisation through the Governance and Quality committee and the Risk and Safety committee. A quarterly Complaints Working Group (CWG) made up of all professionals involved in investigating complaints also discussed cases where lessons were learned with wider implications which could then be shared across the trust. All staff were invited to quarterly workshops dealing specifically with complaints, where relevant and recurring topics were discussed in depth.

Are end of life care services well-led?

Good



We rated well-led as Good because:

- The service had recently drafted a clearly defined vision and strategy to improve palliative care provision across the trust.
- Regular meetings and forums took place that addressed issues in EOLC with various stakeholders. This included a specific EOLC steering group that met quarterly to discuss any issues specific to EOLC.
- Senior staff at all levels were described as supportive and approachable.
- Quality improvement and research projects took place that drove innovation improved the patient experience.

- The SPCT had a monthly meeting. The outcomes of this meeting were fed into the EoLC steering group which met every three months to discuss issues raised, resolutions and policies. There were also mortality and morbidity meetings every three months.

However:

- The hospital failed to meet four organisational KPIs in a national audit published in 2016, including there being no lay member with responsibility for EOLC on the trust board. A lay member currently sat in on the EOLC steering group, which reported directly to the board.
- The data collection methods were not in place to allow effective audits of service wide data until recently.

Vision and strategy for this service

- The trust had recently developed an EOLC strategy which aimed to ensure those in the last stages of life received safe and individualised care as mandated by the five priorities of care (One Chance To Get It Right, 2014). The strategy also took into consideration the elements of other nationally published documents such as 'Ambitions for Palliative and End of Life Care' (National End of Life Care Programme, 2015) and 'Care of the Dying Adult in the Last Days of Life' (NICE, 2015). The strategy aimed to increase recognition of the dying patient and providing high quality EOLC by 2020. A detailed action plan was drawn up that focused on an education programme led by the specialist team but delivered by practice educators and ward EOLC champions. Once this was embedded, the specialist team planned to look into ways of delivering further advanced care planning (ACP) and options for community/local support and management at an earlier phase. This would include development of electronic data sharing systems, such as the electronic multi agency care plan recording system.
- Most of the staff in the specialist team were aware of the aims of the strategy and were able to discuss current developments that would enable targets to be achieved. An EOLC steering group was set up in December 2015 to track the progress of the strategy and ensure that goals and targets were being met.

Governance, risk management and quality measurement

- Issues relating to EOLC were regularly reported and discussed at the EOLC steering group that was set up in

End of life care

December 2015. The group initially met every two months but now meets every three to discuss issues relating to the EOLC strategy, education, risks, complaints, incidents, establishment and resources, amongst other topics. A monthly meeting of the specialist palliative team fed into this. There was also a monthly mortality and morbidity review group.

- Service leads also met monthly to discuss issues relating to governance of the service within the Rehabilitation and Therapies Directorate. Each service lead could then share any relevant information and feed back to their respective team members. Agenda items included trust wide updates, finances, governance and safety (including review of the risk register), seven day working and individual service updates.
- There were also quarterly unit meetings, through which service wide issues and changes were discussed and shared with a wider group of staff. The trust stated it was mandatory for all staff of band 7 and above to attend, whilst other staff could attend if their clinical caseload permitted.
- We were told by staff that there were two risks relating specifically to EOLC on the current trust risk register. On the version provided by the trust, the only item specific to EOLC was regarding the 'assurance framework' and the risk of staff not knowing who to contact for specialist advice. This was due to their being a service level agreement (SLA) between Harefield hospital and another NHS trust. However, staff on the specialist team told us that this was now working well and governance arrangements were clear in regards to service provision. The second risk related to syringe driver competency amongst general ward staff. This was currently being addressed by an increased educational programme.
- A health and safety risk assessment took place in April 2016 within the mortuary at Harefield hospital. Five risks were identified, including: access to the mortuary (there was no ramp in place), portable appliance testing (PAT) of equipment, replacement of fire extinguishers, inadequate racking systems for organ storage and the air conditioning system. Actions were taken to ensure that the histopathology department were included on the PAT testing system.

Leadership of service

- The specialist team sat within the Directorate of Rehabilitation and Therapies, which was restructured in 2011 to further utilise multi-professional therapy team

working. This was intended to allow greater integration and flexibility between the different disciplines in the directorate. The Directorate was led across both sites by the Director of Rehabilitation & Therapies. Additionally there was a Governance & Safety Lead who facilitates clinical governance, quality and safety for the Directorate. In speaking with both the Director and members of the specialist team, they saw no issues in the governance or leadership structure of the service and believed it to be well placed within the hospital structure.

- In the 'End of Life Care Audit: Dying in Hospital' in 2016 the trust failed to meet four organisational key performance indicators (KPIs). There was no non-executive director (NED) on the trust board (in common with 51% of hospitals audited nationally) and no dedicated EOLC facilitators (a new KPI as of May 2015, which 59% of hospitals had achieved). There was also no formal in-house EOLC training in communication for medical staff or allied health professionals and no seven-day face-to-face service. The specialist team were addressing educational needs through the EOLC strategy action plan. The other KPIs were yet to be considered due to the relatively small size of the service and recent major strategic changes.
- Staff within the specialist team were familiar with the senior team, both locally and at board level. The lead nurse of the service was held in high esteem by their colleagues. The specialist nurses felt fully supported within their work, and by their team. They reported that the lead nurse had brought about many positive changes within the specialist team since their post was confirmed in April 2016. The lead nurse worked across both sites for the trust, and brought the two sites together to encourage a positive working relationship between counterparts. This had enabled idea sharing, learning and training to take place, and has started to promote consistency across both sites.

Culture within the service

- All the staff that we spoke to from the specialist team and the clinicians that worked alongside them felt that there was a good atmosphere within the hospital. They felt supported by their colleagues and the wider hospital teams. Staff felt that working at Harefield hospital felt like being part of a family, with some commenting that they would never think of working anywhere else. The specialist team felt that they were

End of life care

starting to be recognised within the trust as being integral to the hospital and care of patients and their families. They had good working relationships with the ward teams, especially the other specialist nurses in different departments who they worked closely with on a daily basis. However, staff in the specialist team acknowledged that there was still more work that could be done in terms of raising their profile across the hospital as they had only been fully operational as a team since April 2016. No issues were raised in relation to cross-site working with the Royal Brompton hospital.

- Staff felt happy and able to raise issues and concerns with their managers. The entire team spoke of an open leadership culture with a flattened hierarchy in which everyone's opinion was considered. A staff member shared with us an occasion where they had raised a concern, and explained how this had been dealt with, including a satisfactory conclusion that led to changes within the department.
- Staff were aware of the need to support each other after a death and the specialist team described how they might support ward staff in the event of a difficult bereavement. The specialist team worked closely with the psychology department to access support where needed. The team were very supportive of each other and did discuss difficult cases both for training, support and reassurance, and to help each other emotionally. This was discussed across both sites at the team webinar that took place every Monday. There was a positive team spirit and this was extended across both sites and support was readily available. The specialist team also had the option to attend counselling appointments with occupational health, if they felt that they needed to have further support.

Public engagement

- The service invited patient and public involvement through various engagement activities, satisfaction surveys, bereavement days, audits and research projects. There was a patient representative present at EOLC steering group meetings. The service took informal feedback from patients and improved small aspects of the service, as well as collating results from national surveys or audits such as the most recent FAMCARE audit or 'End of Life Care Audit: Dying in Hospital' audit from 2016. Action plans were in place for patient survey results and improvements that could

arise from their outcomes. For example, the specialist service planned to develop a new information leaflet including what to expect when someone is dying as this was recognised as a need.

- The hospital consultants were always available to meet with all relatives that had lost someone close to them at the hospital, approximately six to eight weeks after death to discuss the patient and their treatment or any concerns.

Staff engagement

- The specialist team actively engaged with staff on the wards and attended various MDT and departmental meetings on a regular basis. This increased the visibility of the team and provided staff across the hospital with easy access to and advice from palliative care services. Ward staff were positive about the knowledge and support they received from the specialist team when caring for dying patients. Some members of the specialist team felt that staff engagement could be better and they could be involved earlier in the patient journey. The EOLC strategy aimed to address this through comprehensive EOLC training for all staff.
- The specialist team lead nurse was working to bring consistency to the EOLC service across both sites. The sites were a considerable distance apart and, therefore, travel between them was time consuming. The lead nurse was working to bring the two sites together by arranging weekly Skype calls between all the specialist team staff across both sites. Staff were encouraged to speak regularly and swap ideas, ask each other for advice, and support each other when they had experienced a particularly difficult case.
- Staff in the specialist team also attended monthly team meetings, quarterly unit meetings, annual away days and monthly mortality and morbidity meetings. The meetings were designed to foster staff engagement, share information and drive forward improvement. Staff had been consulted on the recently introduced EOLC strategy and changes had been made as a result. For example, greater consideration of paediatric EOLC had been raised as a concern and addressed within the revised strategy and steering group meetings.

Innovation, improvement and sustainability

- The hospital was part of the London Cancer Alliance (LCA) Palliative Care Group. The lead nurse attended monthly meetings with an aim of supporting and

End of life care



sharing good practice across north-west and south-west London. Additionally, the LCA held quarterly study afternoons which were open to all palliative care professionals, delivering talks and disseminating the work of the LCA group.

- A quality improvement plan had been put forward by a senior nurse to improve EOLC within the adult intensive care unit (AICU), via a competition held at the hospital. It was felt that this initiative would assist healthcare professionals with end of life patients, to ensure they had appropriate protocols and guidelines, and to ensure appropriate documentation was completed.
- The hospital had introduced the TEC (Transplant Enhanced Care) system. This introduced patients to the specialist team at the beginning of their transplant journey and ensured that they were involved in their care throughout the patient journey. The specialist team supported patients and their families to consider potential complications and difficult decisions that needed to be considered in advance of treatment. This created a multidisciplinary (MDT) approach to the patient's needs and treatment. The specialist team had developed a prognostic tool for use with TEC patients to identify those patients that were approaching end of

life. Anecdotal feedback suggested that the tool assisted staff to provide early symptom control and prolonged life expectancy within this patient group. The trust won an award for this innovation in the United States of America. The trust felt that the TEC system had been so successful that they had hoped to use the same model for patients with advanced heart failure.

- The specialist team recruited nurses from other wards on a secondment basis, to train them in EOLC. The last nurse that underwent this secondment was from the ICU (Intensive Care Unit), and returned after there after training to become the ward EOLC champion.
- The specialist team had conducted quality improvement projects and audits in areas such as patient experience of use of handheld fans to relieve breathlessness. Further detailed audits were planned for the coming year due to the restructuring of the way data was collected and coded. Senior members of the specialist team were involved in on-going research and spoke at a number of conferences. The specialist nurses had delivered external training to GPs. The team were committed and passionate about improving the service they provided, as demonstrated by the active implementation of the recently instated EOLC strategy.

Outpatients and diagnostic imaging

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

Information about the service

Harefield Hospital is a specialist cardiothoracic (heart and lung) hospital and heart and lung transplant centre. Harefield Hospital provides outpatient care to patients from all over the UK.

The hospital offers a range of services for outpatients, including cardiac (heart), thoracic (lung), transplant, radiology and pathology services.

The outpatients department at Harefield Hospital organises all outpatients clinics, the department provided 208,843 outpatient appointments between April 2014 and April 2015. The department includes general outpatients as well as transplant outpatients.

The imaging department at Harefield Hospital specialises in a spectrum of cardiac, thoracic and non-invasive vascular imaging. It provides specialist imaging services to support cardiology, thoracic medicine, cardiac and thoracic surgery including heart and lung transplantation.

Outpatient care and diagnostics and imaging are also provided to NHS and private paying patients.

The departments we visited during our inspection were: the pre-assessment clinic; imaging; non-invasive cardiology; transplant outpatients; nuclear medicine; lung function; day case unit; cardiothoracic surgery ward; rehab and therapies.

Summary of findings

We rated this service as good because:

- Safety procedures and maintenance contracts were in place for specialist equipment. Radiation protection and medical physics support were available and policies and procedures could be accessed by all staff.
- All medicines were stored securely and medical records were available for all patients in outpatient clinics.
- Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based and followed national guidance and staff worked together in a multi-disciplinary environment to meet patients' needs.
- Staff were competent to perform their roles and took part in benchmarking and accreditation schemes.
- Outpatient and diagnostic services were delivered by caring, committed and compassionate staff and care was planned that took account of patients' needs and wishes.
- The trust was consistently above the England average for the 31 day cancer waiting times from April 2015 to April 2016.
- Diagnostic waiting times were consistently below the England average from January 2015 to January 2016.
- The 'did not attend' DNA rate was below the England average from September 2014 to August 2015.

Outpatients and diagnostic imaging

- The percentage of diagnostic waiting times over six weeks was consistently lower than the England average between October 2013 and January 2016. The only exception was July 2015.
- The level of complaints received regarding outpatient services was consistently low. Staff worked to address any concerns raised by patients at first point of contact.
- Arrangements were in place to accommodate people in vulnerable circumstances.
- Managers and clinical leads were visible and approachable and had a good knowledge of performance in their areas of responsibility. There was an open and honest culture within the service, morale was good and there was evidence of continuous improvement and development of staff and services.
- Diagnostic and imaging services provided a number of examples of outstanding practice, including working with industry to develop new technologies.

However,

- The performance for the 62 day cancer waiting time was consistently below the England average from April 2015 to April 2016. The trust informed us they had implemented a number of improvement actions to improve pathways and referral times; these included actively working with other providers.
- Staff and patients told us some clinics regularly started late and led to longer waits for patients.
- Space across the hospital posed challenges for storing equipment.

Are outpatient and diagnostic imaging services safe?

Good



We rated safe as good because:

- Staff were aware of how to report incidents and could clearly demonstrate how and when incidents had been reported. Lessons were learnt from incidents locally and staff felt confident in raising incidents through the reporting system.
- Policies and procedures were in place for the prevention and control of infection and maintenance contracts were in place to make sure specialist equipment was serviced regularly. However, there were issues in some departments due to a lack of space.
- There were appropriate protocols in place for safeguarding vulnerable adults and children, and staff were aware of the requirements of their roles and responsibilities in relation to safeguarding.
- Staffing levels and skill mix were planned to ensure the delivery of outpatient diagnostic services at all times.
- All medicines in outpatients were found to be in date and stored securely in locked cupboards.
- An electronic patient record (EPR) was used which ensured availability of medical records for outpatients clinic.
- Staff were able to describe the procedure if a patient became unwell in their department and knew how to locate the major incident policy on the intranet.

Incidents

- The service had systems in place to ensure that incidents were reported and investigated appropriately. All the nursing and medical staff we spoke to stated that they were encouraged to report incidents via the electronic incident data management system. Radiology had 120 incidents in 2015. In 2014 there were 83 incidents, of which seven were recorded as IR(M)ER related incidents (three in computerised tomography (CT) scanning and four in X-ray). CT had the highest rate of incidents. Both CT and X-ray incidents increased between 2014 and 2015 due to an improved reporting culture through local benchmarking audits

Outpatients and diagnostic imaging

- There had been no never events or serious incidents requiring investigation reported between March 2014 to April 2016 to the strategic executive information system, (STEIS).
- From April 2015 to March 2016 there had been: 52 incidents reported by X-ray; 29 incidents reported by CT scanning; 12 by nuclear medicine; and five by magnetic resonance imaging (MRI).
- The outpatients department between April 2015 to March 2016 reported 10 incidents; transplant outpatients reported nine incidents in the same period.
- Incidents were monitored by the trust's governance and safety team for trends. The lead sent electronic incident reports to team leaders monthly.
- Incidents were standard agenda items at monthly 'safety and governance meetings.' SI investigations were sent to departmental leads prior to the meetings. The monthly meetings were attended by a staff representative from each service area. The minutes of these meetings showed that incidents were a standing agenda item and discussed at the meetings. Where incidents had been reported a full investigation had been carried out and steps were taken to ensure lessons were learnt. Action plans were produced following investigations. These were monitored and tracked to completion at subsequent meetings. Staff told us that learning from incidents was cascaded to staff at team meetings.
- The service lead received safety alerts and was responsible for taking action to respond to relevant alerts. This included discussion of alerts at the 'safety and governance' meeting. Staff told us completed actions would be reported to the Department of Health's (DOH) central alerting system (CAS).
- Staff told us they understood their responsibilities to report incidents using the electronic reporting system, and knew how to raise concerns. Staff confirmed that they received feedback on incidents that took place in other areas of the service as well as their own. Staff and managers told us they were satisfied there was a culture of reporting incidents promptly within both the outpatients and diagnostic imaging departments. Incidents were audited on the trust's electronic reporting system by the governance and safety team.
- The outpatients department used the 'safety cross' to measure: staff sickness, falls, infections and 'did not attend' appointments rates.
- There is a duty of candour (DoC) imposed on all NHS providers. The duty of candour is a regulatory duty that relates to openness and transparency and requires providers of health and social care services to notify patients (or other relevant persons) of certain 'notifiable safety incidents' and provide reasonable support to that person. Staff and managers we spoke with were aware of and able to explain the 'duty of candour'. Staff told us the 'duty of candour' was included in the trust's safeguarding training. The outpatients department matron said they had never used the DoC formally. However they were honest with patients if clinics were running late and offered patients' opportunities to re-book appointments.

Cleanliness, infection control and hygiene

- Overall we found the outpatient department and diagnostic and imaging services were compliant with the "Code of Practice on the prevention and control of infections and related guidance" issued by the Department of Health in 2010.
- Policies and procedures for the prevention and control of infection were in place and staff adhered to "bare below the elbow" guidelines. Personal protective equipment (PPE) and hand gel was readily available in all clinical areas and we observed staff using it.
- Patients were cared for in a clean, hygienic environment. All of the clinical areas we visited were clean and well maintained. We inspected toilets and sluices and found them to be clean. However, we found the sluice in the outpatients department was unlocked. We alerted staff who locked the door immediately. The trust informed us that hazardous substances were kept in locked cupboards in the sluice. There was a risk that unauthorised people could have gained access to the equipment in the sluice.
- Clean equipment had an 'I am clean' sticker applied when it was cleaned.
- Clinical waste was removed and bins for sharp items were correctly assembled and labelled.
- OPD had a link nurse for infection prevention and control (IPC) that was responsible IPC in the outpatients department. The departmental link nurse liaised with the trust's IPC specialist nurse. The departmental link nurse attended IPC meetings with the trust's IPC specialist nurse and could approach them for advice on IPC. The IPC nurse also disseminated IPC learning from the meetings at outpatient department staff meetings.

Outpatients and diagnostic imaging

- We observed cleaning taking place and saw cleaning schedules. We noted that staff initialled charts when they had completed cleaning tasks. Supervisors checked completion and the matron told us they did 'walk arounds' regularly to monitor cleanliness. The trust's executive team also did regular 'walk arounds' as part of a programme of safety inspections.
- Staff told us outpatients did not complete hand hygiene audits as sinks were in clinical rooms and staff used an ultraviolet light in the rooms to ensure their hands were clean. However, hand hygiene audits completed between January 2015 and December 2015 indicated that outpatient and diagnostic departments consistently achieved the target compliance rate of 90%.
- Alcohol gels were available outside of all clinical rooms on the outpatients department with clear signage asking staff and patients to gel their hands prior to entering. Alcohol gels were also available at reception.

Environment and equipment

- Across outpatients and diagnostic imaging we saw that services kept up to date medical device inventories.
- Maintenance contracts were in place to ensure specialist equipment was serviced regularly and faults repaired and we saw evidence of quality assurance for diagnostic equipment.
- Safety testing for equipment was in use across outpatients and diagnostics and the equipment we reviewed had stickers that indicated testing had been completed and was in date.
- Clear signage and safety warning lights were in place in the x-ray departments to warn people about potential radiation exposure.
- Occupational exposure to radiation was monitored for radiology staff. This ensured that the amount of radiation staff were exposed to as part of their work was checked. The department of nuclear medicine had been assessed as compliant by an independent health and safety inspection in July 2015.
- PPE was available to staff across outpatients, diagnostic and imaging departments.
- We found the resuscitation trolleys located throughout the departments were locked and medicines and stock inside the trollies were appropriate and had been checked daily and twice on Fridays. Staff reported that these checks were high priority. Defibrillators were tested on a daily basis. Overall, most oxygen cylinders

we looked at were all in date. However, we noted that three out of five cylinders in the transplant outpatients were partially used; one was on red level approaching empty.

- Portable oxygen and suction equipment was available in the X-ray department. We found the equipment was checked daily.
- Some staff told us the age of some parts of the hospital could present a challenge in terms of equipment storage. However, we did not see in any of the departments we visited equipment stored where it might pose a risk to the public or unsupervised equipment that could have been tampered with.
- Staff at the transplant outpatients department told us storage space was a challenge. A staff member told us, "We are a department that has outgrown itself." Staff added that the board were aware and discussions were taking place in regards to new premises on the Harefield Hospital site. The lack of storage space was on the departments risk register.
- Harefield Hospital had a mobile MRI unit for cardiac (heart) and thoracic (lung) imaging available five days a week. Staff told us the unit had increased the hospital's MRI capacity. The mobile MRI was identified on the departments risk register as a temporary measure whilst the trust built a new imaging centre on the hospital site, which had been delayed by the planning process and out of date tenders.

Medicines

- Medicines were stored in locked cupboards and there were no controlled drugs or intravenous fluids held in the department.
- All outpatient clinic areas had registered nurses on duty during clinic opening hours and they signed for the medication storage keys.
- Lockable fridges were available for those drugs needing refrigeration; temperatures were recorded daily when the department was open. However, we noted that some temperature records for four days in June 2016 were above that recommended for the safe storage of medicines. Staff told us the fridge was new and the company that supplied the fridge had installed a new SIM card to regulate the temperature. We saw that since the SIM card had been installed temperatures were within the required range.

Outpatients and diagnostic imaging

- Annual medicines storage audits were undertaken. The results were good and showed staff followed medicines storage policies appropriately.
- Prescription pads were stored securely and their appropriate use monitored.
- Pharmacy staff reinforced medicine safety instructions and information to patients when they collected their prescriptions following their consultation. Many of the specialist nurses also provided information and support about medication as part of the patient's consultation.
- Medicines management was discussed in a "stressor meeting" of the department of nuclear medicine on 15 September 2015.
- There were policies and procedures in place to provide guidance for outpatients staff. For example, we viewed the policies for: 'giving out prescriptions'; 'prescribing, supply, and administration of medicines'; and the procedures for 'the supply, security, administration and destruction of controlled drugs'.

Records

- Patients' records were managed in accordance with the Data Protection Act 1998.
- The EPR provided staff with access to letters, reports, imaging and test results. Staff told us a new electronic patient record (EPR) was being rolled out in August 2016, due to limitations with the current EPR. Most patient records were paper based, including risk assessments.
- Paper based notes were kept in locked keypad trolleys. However, staff at the transplant outpatients department told us storing notes was an issue due to a lack of space.
- We viewed six patients care records. For example, patients discharge summaries and referral letters were in their care records, together with risk assessments that included a record of patients' allergies, activities of daily living (ADL), whether they were at risk of venous thromboembolism (VTE), and whether they had an assessment of mental capacity.
- Imaging requests for inpatients were completed electronically. Requests from general practitioners were a combination of electronic and paper referrals.
- Information governance was part of the trust's mandatory training. Staff told us they had received information governance training. The staff training spreadsheet recorded that 100% of staff were up to date and had completed mandatory training in information governance.

- Leaflets explaining patients' rights to access their medical records were available in all the departments we visited. The trust's website carried information on people's rights under the Freedom of Information Act 2000.

Safeguarding

- Safeguarding policies and procedures were in place across the trust. These were available electronically for staff to refer to.
- Staff were aware of their roles and responsibilities and knew how to raise matters of concern appropriately.
- Staff were able to describe different types of abuse.
- Bank staff received the same safeguarding training as permanent staff and ad hoc training was also provided by safeguarding team as and when required.

Mandatory training

- We viewed the outpatients' department mandatory training spread sheet. We found that most mandatory training was up to date. Mandatory training included: fire safety; health and safety; moving and handling loads; safeguarding; medicines management; equality and diversity; and prevent.
- 100% of outpatients department staff had completed mandatory safeguarding training in both children and adults level 1; 50% of nursing staff had completed safeguarding children level 2. However, 50% of nursing staff had completed equality and diversity training. The figure for HCAs was 100%; and 50% of nurses had completed training in prevent, but there was a rolling programme of training and staff had dates to update their mandatory training.
- Training for staff in basic life support was mandatory in the outpatients department, this included staff working on the department's reception desk. 100% of staff had completed basic life support training.
- Minutes from nuclear medicines staff meeting dated 23 March 2016 recorded a discussion in regards to staff mandatory training.

Assessing and responding to patient risk

- There were arrangements in place to deal with foreseeable medical emergencies. Senior managers told us that escalation of risk was normally done from a ward

Outpatients and diagnostic imaging

level. Ward managers discussed risk with their line managers who escalated to the service director, then onto the risk register if required. The deputy directors meeting regularly reviewed the risk register.

- The trust had a policy for managing deteriorating patients. This included comprehensive guidance for staff on the trust's resuscitation procedures and staff roles and responsibilities. For example, minutes from the nuclear medicine teams 'stressor meeting' dated 14 September 2015 documented the review of the department's protocol for managing a sick patient.
- Referrals were immediately logged onto the EPR, which identified patients who were at risk of deteriorating.
- All staff working in the outpatients department had completed 'basic life support' training. In addition, nursing and medical staff all received immediate life support training (ILS), and could act as first responders to patients in cardiac arrest until the medical emergency team arrived.
- If a patient became unwell in outpatients, the service had a clear protocol to follow. Staff would treat the patient within the department and either transfer them to the nearby acute hospital or to a ward within the main hospital for full assessment and treatment. Staff were able to talk about and demonstrate a good knowledge of the emergency procedures.
- Clear signs were in place informing patients and staff about areas where radiation exposure took place.
- Safety procedures were in place in radiology and we observed staff obtaining name, address and date of birth of patients prior to examinations which is a requirement of the Ionising Radiation (Medical Exposure) Regulations (IR(ME)R)(2000).
- Notices were in place in x-ray rooms to remind staff to 'pause and check' before scanning and we observed this in practice. Pause and check is a further process to ensure safe and effective patient care.
- Staff were able to describe the procedure if a patient became unwell in their department including calling the medical emergency team.
- If a patient required hospital admission following review and treatment by the medical emergency team, transfer was arranged either to a ward or by ambulance to the nearest accident and emergency department depending on the nature of the patients' illness.
- The interim radiation protection committee met annually to review the safety of the use of radiation in the hospital. Minutes from the committee meeting

dated 17 September 2015 looked at the trust's local rules in regards to the use of radiation as well as the trust policies, risk assessments, and IRMER protection for staff.

Nursing staffing

- Nursing services in the outpatients department were provided by the outpatient nurses and clinical nurse specialists (CNS). For example, allergy, heart failure, angioplasty (procedure unblocking blood vessels or coronary arteries), and tissue viability (TV).
- Staff told us there were sufficient nursing staff to ensure shifts were filled in line with their agreed staffing numbers. A safe staffing dashboard was displayed in the outpatients department. This showed details of the required levels of staffing, and actual levels present on each day. Staffing levels were adequate, as was the required skill mix at the time of our visit. The matron demonstrated an online acuity tool which was used to assess the required staffing levels for each day.
- There was a bank for nursing staff so the hospital had cover for staff sickness and holidays. Bank staff had an induction and mandatory training was provided. Many of the bank staff had worked at the hospital before and were familiar with the trust's processes.
- The outpatients risk register identified the recruitment and retention of critical care nurses as a potential risk. To address the risk there was on-going recruitment of band 5 and band 6 nurses. The trust was also developing a strategy for the recruitment of critical care nursing staff.

Medical staffing

- Medical led clinics had a sufficient number of medical staff to support outpatients' clinics.
- Within the radiology and diagnostic centre we found a sufficient number of staff on duty to meet the daily demand of diagnostic services.
- The outpatients risk register identified the recruitment and retention of band 6 radiographers. There was one vacancy for a band 6 radiographer. This was covered by an agency radiographer. Agency radiographers completed the hospital's competency assessment before they could work on their own. The hospital were advertising the position and recruitment was on-going.

Major incident awareness and training

Outpatients and diagnostic imaging

- Staff were aware of the trust's business continuity policy; senior staff understood their roles and responsibilities within a major incident. Staff told us there were staff allocated to assist in the event of a major incident.
- The emergency planning and business continuity manager prepared staff to respond to a major incident and worked with the site management team to assess current risks. We were told staff were encouraged to attend major incident training. Some staff told us they had attended a major incident strategic planning day in February 2016.
- Staff in the nuclear medicines team had conducted a mock exercise into the 'theft of radioactive sources' in March 2016.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

- Patients attending outpatients and diagnostic imaging departments received care and treatment that was evidence based, with some staff at the hospital involved in developing National best practice guidance.
- Staff worked together in a multi-disciplinary environment to meet patients' needs. Specialist nurses were available in a wide range of specialities.
- Staff were competent to perform their roles and took part in benchmarking and accreditation schemes. Staff were supported in their roles by ongoing specialist training and development opportunities.
- Information relating to patients health and treatment was available from relevant sources before a clinic appointment and staff had access to previous x-ray images. Information was shared with the patient's GP following hospital attendance to ensure continuity of care.
- The trust rate of follow up appointments in relation to new appointments was higher than the England average from August 2015.

Evidence-based care and treatment

- Staff at the hospital had been involved in developing National best practice guidance. For example, the interim director at Harefield Hospital was a specialist

advisor to the National Institute for Health and Care Excellence (NICE) on the use of laser sheaths in pacing lead extraction. Also, the department of nuclear medicine had assisted NICE in publishing guidance for cardiac nuclear medicine imaging.

- Safety procedures were observed in radiology to ensure the right patient got the right scan at the right time.
- Staff in catheter laboratory (cath lab) used the World Health Organisation (WHO) surgical safety checklist adapted. This aims to reduce harm during operative procedures by using consistently applied evidence-based practice and safety checks to all patients.
- Staff at the department of nuclear medicine showed us an IRMER manual staff had access to, and demonstrated how staff could access trust policies and guidelines on the trust intranet.
- Cardiac rehabilitation was an evidenced-based practice using secondary prevention measures and modification of lifestyle behaviours along with drug intervention to minimise the risk of patients experiencing further cardiac events and to improve symptoms in patients suffering with chronic heart disease.
- The 'care for your heart' rehabilitation programme was broken up into phases. Harefield provided services for phases 0-III and could refer patients to phase IV programmes in community settings once they finished the hospital programme.
- Diagnostic and imaging services had standard operating procedures (SOP) for all procedures performed by the service.
- Imaging and nuclear medicine were working towards ISAS accreditation, this was a pathway based on the NHS England, 'Putting patients first business plan 2016-2017', a nationally recognised scheme for diagnostic and imaging services.
- Managers told us the introduction of a new IT system had provided the trust with the opportunity to review all patient pathways. Work was in progress with cross site groups at Royal Brompton and Harefield hospitals that were looking at improvements to patient outcomes, and this work would feedback to a trust steering group.

Pain relief

- Staff were able access appropriate pain relief for patients within clinics and diagnostic settings.
- Staff told us they could bleep the pain management team who would attend to a patient experiencing pain.

Outpatients and diagnostic imaging

- Records confirmed that patients' pain needs were assessed before undertaking any tests in the majority of cases.

Patient outcomes

- The Imaging Services Accreditation Scheme (ISAS) scheme provided a framework for imaging services to measure and ensure practice was patient-focused. The scheme involved an assessment and accreditation programme designed to help diagnostic imaging services ensure that their patients consistently receive high quality services, delivered by competent staff working in safe environments.
- We viewed the outpatients department's audit plan dated 11 November 2015, this enabled managers in monitoring of the progress of local audits. We also viewed the nuclear medicines audit list for 2016, we saw that audits were in progress or dates were arranged for audits.
- Staff told us the roll out of the trust's new IT system would enable improved monitoring of patient outcomes. We saw that plans were in place for implementation of the IT system in August 2016.

Competent staff

- Staff received annual appraisals. For example, the outpatient department had a 97% appraisal rate for nursing staff. The appraisal rate for consultants across the trust was 96%. We viewed the staff survey 'frequency report 2015' for the imaging department 85% of staff confirmed they had received an appraisal in the previous 12 months.
- Staff received regular supervision and team meetings.
- The outpatients department provided clinical support for nursing staff: This included: one whole time equivalent (WTE) Band 7 practice educator, three WTE clinical nurse facilitators, clinical peers, buddies and mentors.
- We spoke with health care assistants (HCA) and observed the care they were giving in clinical areas. Some HCA's were trained for specific tasks, for example taking blood or taking physiological measurements. HCA's told us they received direct supervision from registered nurses. HCA's told us their electronic training records recorded any specialist training they had undertaken and they received emails to notify them when training updates were due.

- Competency assessments were in place for outpatients and diagnostics and induction processes were in place for new staff.
- Staffs were able to obtain further relevant qualifications. Staff said there were plenty of development opportunities, and staff was encouraged to broaden their skills base. There were a range of in-house training opportunities.
- Staff using diagnostic and imaging equipment were trained in its use. For example, imaging business meeting minutes dated 3 March 2016 recorded that staff had been trained and had their competence assessed in the use of a new CT-scanner, (a computer that converts multiple x-ray images into pictures on a monitor). The nuclear medicine department had an agency radiographer who was not authorised to perform any procedures until they had passed all relevant competencies.
- Staff told us they were supported with revalidation of their registration with their professional regulatory bodies. For example, we saw the registrations of staff with the administration of radioactive substances advisory committee (ARSAC) in the nuclear medicine department.
- Staff at the non-invasive cardiology department received training in "human factors" to promote safety and enhance staff efficiency.
- There were clinical governance days and 'away days' where staff could look at practice issues and 'action learning'.
- Staff at the transplant clinic had been supported to attend an international conference on transplants to keep up to date with current and emerging practice initiatives.

Multidisciplinary working

- There were regular multidisciplinary team (MDT) meetings in outpatients, diagnostics and imaging. We observed a MDT meeting for cardiac sarcoid disease; this was attended by cardiac consultants and nuclear medicines staff, CNS's and the palliative care support team. We saw staff discussing the outcomes of individual patient's interventions as well as clinical decisions, and the patients' journey from admission to planned discharge.

Outpatients and diagnostic imaging

- The OPD ward sister attended 'network' meetings every two weeks. This gave staff across the network the opportunity to exchange ideas. For example, the service had taken on-board clinical rounds as a result of attending the meetings.
- Therapists including OT and physiotherapists were part of the outpatients department MDT.
- The image transfer team had recruited two new administrators to facilitate transfers of patient images so that patients did not have to undergo repeat imaging and ensure patients' images were available to their MDT.
- Staff at the imaging department told us they collaborated closely with physicists, doctors and radiographers.
- The cardiac rehabilitation team provided patients with MDT assessments involving nursing and physiotherapy assessment, cardiac risk factors identification and modification, education, support, counselling and prescribed exercise, as well as medical evaluation.
- The department of nuclear medicine attended MDT meetings with staff at a local general hospital. There were also cross-site MDT's with nuclear medicine staff at the Royal Brompton.
- The imaging service had service level agreements with external providers. For example, the cardiac oncology service collaborated with staff at a specialist cancer hospital for patients with cancers. The nuclear medicine department had service level agreements with the cancer hospital for specialist positron emission tomography (PET) and computed tomography (CT), PET-CT, scanning, this was a scanner that looked at the function of the body's cells and tissues.
- Patient information was shared with GP's following hospital attendance to ensure continuity of care.

Seven-day services

- Outpatients' clinics operated from 9.00am to 5.00pm Monday to Friday. There were no regular weekend clinic appointments in the outpatients department, even though some clinics had been offered at weekends. Staff said there had been a lack of demand for patients for weekend clinics.
- The diagnostic and imaging departments provided services such as blood tests and x-rays at the weekend; an x-ray technician was on-call out of hours (OOH) seven days a week. CT scanning and cath lab provided a 24 hour on call service seven days a week.

Access to information

- Staff across all the departments we visited demonstrated how they could access all the information needed to deliver effective care and treatment in a timely way from the EPR. Staff showed us how they used the EPR to gain access patients test results.
- Diagnostic results were recorded on patient EPR's, giving staff across the trust immediate and up to date access to patients' records.
- The radiology department used a nationally recognised system to report and store patient images. The imaging department's picture archiving and communication system (PACS) allowed access to all imaging from anywhere within the trust.
- Previous images could be viewed by staff. There was same day imaging with CT-scans, a system that makes use of multiple x-ray images; echocardiograph (ECHO), a system that creates ultrasound images of the heart; and x-rays. This meant patients images could be viewed on the day they attended clinics.
- The outpatients department had a preparation room. Staff received up dated patients' clinical information in the preparation room in readiness for clinics. Paper records we saw were up to date and written clearly.
- The outpatients department had introduced a clinic co-ordinator who took all calls and messages to the service and disseminated information to staff. There was a rota that identified nursing staff that were covering the role. Staff said the introduction of a co-ordinator had improved communication in the department.
- The service were rolling out a new electronic records system in August 2016, with the intention of improving the accessibility of patient information.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff in outpatients and diagnostic imaging worked on the principle of implied consent. This meant staff worked on an implicit assumption that people had attended their appointments and therefore consented to their care and treatment. Staff also obtained verbal consent when examining and treating patients.
- If written consent was required for more complex procedures this was obtained in outpatients' clinic by medical staff.
- Clinical nurse specialists were able to describe the process of assessing capacity when obtaining consent.

Outpatients and diagnostic imaging

- However, we viewed the training record for the outpatients department and found that nursing staff and HCA's did not have up to date training in the Mental Capacity Act 2005, deprivation of liberty safeguards (DoLS), or prevent. This meant staff were at risk of not complying with the Mental Capacity Act code of practice 2007 in regards to patients lacking capacity consent to care and treatment.
- Staff were encouraged to document best interest and capacity decisions. For example, we saw from reviewing meeting minutes that consent was discussed with staff in the nuclear medicine 'stressor meeting' dated 15 September 2015.

Are outpatient and diagnostic imaging services caring?

Good



We rated caring as good because:

- We spoke with 12 patients and relatives. All were positive about the way staff treated people. People thought that diagnostic and imaging staff went 'the extra mile'. Patients told us the care they received met their expectations. There was a strong, visible person-centred culture in all the departments.
- Staff were motivated and offered care that was kind and promoted people's dignity. We observed staff being caring and supportive in interactions with patients and their families.
- Patients and relatives told us they were involved in decision making about their care and treatment. However, a few patients told us they did not fully understand the care and treatment choices available to them. People's individual preferences and needs were reflected in how care was delivered.
- Staff demonstrated awareness of people's needs and the limitations associated with their conditions. Patients' psychological and emotional needs were appropriately supported.

Compassionate care

- Patients in the outpatients department spoke positively about the staff that supported them with their care and treatment and considered them knowledgeable and professional. We did not receive any negative comments

from patients, their relatives or carers about staff attitudes or behaviour towards them in either the outpatients department or diagnostic and imaging services.

- Patients, families and carers we spoke with in diagnostic and imaging services were overwhelmingly positive about the care and treatment they received from diagnostic and imaging services. For example, a patient in the outpatients department told us, "I think the staff are caring." Another patient told us, "They are OK."
- Staff at the outpatients department told us they could have a patient electronic call system, but thought it was important that patients were called and escorted to their clinical room in person. We saw staff escorting people to clinical rooms.

Understanding and involvement of patients and those close to them

- Overall, patients and relatives told us they were involved in decisions about their care and treatment. However, one patient told us, "I need a valve replacement and will have to go to the Brompton. I don't really understand why."
- We observed nursing staff seeking consent before carrying out tasks.
- The trust completed an outpatients survey in 2015. The results showed in comparison with other trusts the trust performed better than average on 27 of the questions asked. For example, 84% of respondents rated their care as excellent or very good. 95% of respondents felt they were treated with respect and dignity all or some of the time. The trust identified from the survey results that they could give patients more information about treatment, improve how the trust managed waiting times in clinics, and improve how the trust explained tests and investigations to patients. Managers and staff told us actions were being taken to address this, including sending texts to patients' mobile phones when clinics were running late.
- Patients at the department of nuclear medicine had access to a telephone or email advice line and could contact the department for advice or information, which would be responded to within one working day.

Emotional support

Outpatients and diagnostic imaging

- Staff told us Harefield Hospital multi-faith chaplaincy could provide listening and emotional support if requested to all patients.
- Harefield Hamsters were a transplant patients peer support group that offered counselling as well as social support for transplant patients. Re-beat were a peer support group for patients who had heart surgery.
- The hospitals psychological medicine service provided psychological and psychiatric consultation, assessment and therapeutic intervention to patients and their families and carers.

Are outpatient and diagnostic imaging services responsive?

Requires improvement



We rated responsive as requires improvement because:

- Patients and staff told us there were often long waits once they had arrived in the outpatient department.
- Trust data showed that 27% of outpatient clinics started late. Staff said this was often due to clinicians turning up late.
- The performance for the 62 day cancer waiting time was consistently below the England average from April 2015 to April 2016. The trust informed us they had implemented a number of improvement actions to improve pathways and referral times; these included actively working with other providers.
- Between April 2015 and March 2016 the trust was frequently below the England average for the referral to treatment (RTT) for incomplete pathways. The trend was negative as RTT times had been deteriorating and getting worse than the average between December 2015 and June 2016. In January 2016. However, following our inspection the trust provided performance data that indicated the 92% target had been met in October 2016.

However,

- The service was responsive when planning the service to meet the needs of local people.
- The trust was consistently above the England average for two week cancer waiting times from April 2015 to April 2016.

- The percentage of diagnostic waiting times was consistently below the England average from January 2015 to January 2016.
- The 'did not attend' DNA rate was below the England average from September 2014 to August 2015.
- The percentage of diagnostic waiting times over six weeks was consistently lower than the England average between October 2013 and January 2016. The only exception was July 2015.
- The level of complaints received regarding outpatient services was consistently low. Staff worked to address any concerns raised by patients at first point of contact.

Service planning and delivery to meet the needs of local people

- Managers told us there were a variety of models for the outpatients department. This included a traditional outpatients model, nurse led clinics, rapid access services, and 'one stop shops.' Staff told us the service was waiting for a new IT system to be rolled out to enable them to complete a comprehensive review of services, this would include capacity and demand.
- The Harefield Hospital outpatients department saw approximately 35,000 patients a year, offering a mixture of nurse and medical led clinics. General outpatient nursing services included a variety of tasks and tests, which included: dressings; injections; phlebotomy, blood tests; urinalysis, urine tests; spirometry, breath tests; body mass index (BMI) measurements, blood pressure measurements; and administration of medicines.
- The outpatients department offered a number of telephone based clinics. Telemedicine was also available to some patients who lived at a distance. Patients had defibrillators at home which could be monitored by the hospital. Some ICD patients had three monthly appointments by remote clinics, this meant patients only attended the hospital for their annual check-up.
- The imaging department provided secondary and tertiary services to local as well as a wider population. The hospital had one of the largest cardiac imaging departments in UK in regards to clinical activity and also had active research programmes. Services included: chest radiography, including some general radiography, ultrasound (US) and Doppler scans, nuclear medicine (a branch of medicine using radioactive substances in research and treatment), and magnetic resonance

Outpatients and diagnostic imaging

imaging (MRI) (a branch of scanning using magnetic fields). Catheterization laboratories (cath lab), (examination room with diagnostic imaging equipment used to visualize the arteries of the heart), were located within and managed by the imaging department with most of the procedures being performed by the cardiologists.

- The trust had a recruitment plan in place to recruit further radiologists, to support a trust initiative in regards to increased use of MRI scans and reductions in the use of radiology.
- Patients had access to a 'one stop shop' model. This meant clinical assessments, MRI, and ECHO could be completed on the same day to avoid patients having to make multiple visits to the hospital.
- The outpatients department had vending machines for snacks and tea and coffee. There were also televisions displaying the BBC news channel with subtitles.
- The cardiology department waiting area had a tea room, as well as a screen for displaying patient information and updates.
- Staff told us there was a trust initiative for increased cross site working with the Royal Brompton hospital.

Access and flow

- The outpatients department provided 208,843 outpatient appointments between April 2014 and April 2015. Of those appointments, 4% were new referrals; this was below the England average of 7%. Most appointments were follow-up appointments and accounted for 78% of all the appointments provided; this was above the England average of 55%.
- The percentage of patients who did not attend (DNA) their appointment was 3%, this was below the England average. There were no appointments cancelled by the hospital between April 2014 and April 2015.
- The trust was consistently better than the England average from January 2015 to December 2015 for the 31 day cancer waiting time.
- The trust exceeded the 93% target for the two week cancer wait times from April 2015 to April 2016. However, the performance for the 62 day cancer waiting time was consistently below the England average for the same period.
- The percentage of diagnostic waiting times was consistently better than the England average between October 2013 and January 2016, with one exception in July 2015.

- We viewed the diagnostics waiting times dashboard dated October 2015 and January 2016. This indicated that 0% of patients waited more than six weeks for services, with the exception of sleep studies all patients were seen within three to four weeks.
- Between April 2015 and March 2016 the trust was below or in line with the England average for the referral to treatment (RTT) of incomplete pathways. The trend was negative as RTT times had been deteriorating and getting worse than the average between December 2015 and June 2016. In January 2016, the Trust began work on a remedial action plan, with a trajectory indicating the 92% standard would be met by March 2017. However, following our inspection the trust provided performance data that indicated the Trust met the 92% target in October 2016.
- The services performance for non-admitted RTT within 18 weeks was similar to the England average for all months, with the exception of October 2015 where performance dropped to less than 60%.
- Harefield Hospital's cardiology, respiratory medicine, surgery and transplant clinics had 2663 new referrals between September 2015 and February 2016. 56% of new patients waited between 0 to 5 weeks to be seen; 42% of patients waited between six to 17 weeks to be seen; 2% of patients waited 18+ weeks to be seen. This was good as the trust target was 95% of new referrals should be seen within 18 weeks.
- The outpatients department provided over 100 clinics a week. Both patients and staff told us there were often long waits once they had arrived in the department.
- A patient told us the average waiting time was, "About two hours, although I have been seen in 30 minutes. It depends how busy they are." Another patient told us, "The longest wait I have had is between four and half and five hours."
- The outpatients care service audit 2015 demonstrated that over 80% of clinics started on time, with the exception of adult congenital heart disease (ACHD) at 75%), thoracic surgery at 70%; ECG at 40%;, intestinal lung disease at 20%; and cardiac surgery at 10%.
- The outpatients care service audit 2015 also recorded that a few clinics regularly finished more than one hour late. These were: cystic fibrosis at 85%; interstitial lung disease at 80%; chronic obstructive pulmonary disease

Outpatients and diagnostic imaging

(COPD) at 10%; ACHD at 20%; cardiomyopathy, diseases of the heart, at 20%; electrophysiology (EP), electrical activities of the heart, at 20%; and intervention clinics at 20%.

- Staff told us clinics were sometimes delayed by consultants arriving late, or more often patients having more complex conditions that required extra time. Staff said they would speak with patients that had appointment times delayed, and that they always announced delays in clinic schedules in the waiting room as well as delay notices being broadcast on the waiting room screens.
- Figures from the trust showed that 27% of clinics started late. Staff at the outpatients department told us clinicians turning up late for clinics could be a challenge in meeting appointment times. However, staff said this was being addressed as the department had completed an audit of clinicians' arrival times at clinics; this data was unavailable at the time of our visit as the audit results were being analysed by the trust.
- Some staff told us a consultant had a clinic arranged at Harefield Hospital from 1.00pm to 5.00pm every week. But the consultant had also arranged to work for another hospital on the same day from 1.00pm to 3.00pm. Staff said this had led to some clinics starting late and patients having their appointment rearranged. The service had a six week cancellation policy and appointments were cancelled six weeks in advance. However, senior managers told us the trust board were aware of the situation and had spoken with consultants to ensure that they worked within their job plans and did not accept work commitments inside the hours specified in their job plans.
- Staff at the outpatients department told us the trust's IT system did not provide information on patients 18 week care and treatment pathways and made monitoring this challenging. However, staff said this would be rectified with the introduction of the new IT system as staff would be able to identify if patients needed to be seen within their breach days.
- Outpatients' clinics ran between 9.00am to 12.30pm; and 1.00pm to 5.00pm. Some patients told us they had not had a choice in regards to the time of their appointment. A patient told us they had an appointment at 9.00am and as they had to travel this meant leaving their home at 6.00am. In transplant the heart clinics were scheduled for the morning; lung clinics were scheduled in the afternoon.
- Imaging appointments for MRI scans from 8.00am to 5.00pm. CT scans were from 8.30am to 5.00pm. There was a two week wait for CT scans.
- The transplant outpatients department saw new patients who were being assessed for their need for a heart or lung transplant following a heart or lung transplant operation patients were followed up regularly in the clinic. Their follow-up appointment included a variety of specialist tests such as a cardiac biopsy. Patients at the transplant outpatients department were provided with parking permits. Porters would escort transplant patients from the car park to the clinic. Patients attending appointments also received three months free transport to and from clinic appointments.
- GP's and acute hospitals could use the outpatients' department 'choose and book' online appointments system, e-referrals, or paper based referrals. However, the 'choose and book' system could not support acute hospital referrals. Consultants triaged referrals and secretaries booked appointments. Staff told us patients could rearrange appointments if the allocated time wasn't convenient, once they had received an appointment letter.
- Staff said same day appointments could be arranged for urgent referrals as departments scheduled urgent appointments daily.
- Patients told us they received instructions with their appointment letters and were given written information as required. The outpatients department had a text booking service where people would receive text notification on their mobile phones to confirm their appointment details. Patients would also receive a text to inform them if their clinic was delayed.
- One stop clinics were available for assessment prior to procedures. Patients attended for a holistic assessment as well as all necessary blood tests and investigations and received advice regarding hospital admission and any alterations to medication. For example, staff told us patients who lived at a distance and had to travel to the hospital could receive electrocardiogram (ECG), (a test used to check the heart's rhythm), and ECHO on the same day.
- The outpatients department had a ticket queuing system. The department had also installed large screens that carried messages for patients, including the current

Outpatients and diagnostic imaging

waiting time. The waiting time on display at the time of our visit was 45 minutes. We saw that on the day we visited most people were seen within the 45 minute waiting time.

- If appointments in outpatients were delayed staff told us they would offer patients a hot drink and a biscuit. They could also offer vouchers to patients experiencing financial hardship to use in the hospital's restaurant, or if the patient was unwell staff told us they could provide a snack box.
- Clinicians decided when patients could be discharged. Staff told us patients being discharged would be advised about support following discharge. For example, some patients had 'open door access', and could arrange appointments following discharge directly with the department rather than having to be referred by a GP.

Meeting people's individual needs

- The outpatients department had access to a range of support to meet their individual needs including: physiotherapy, a specialist speech and language therapist for voice, ear nose and throat (ENT) and respiratory disorders, pulmonary rehabilitation and oxygen services.
- The outpatient risk register recorded ECHO facilities not meeting national and European recommendations due to the layout of the department posing a risk to patients' privacy and dignity. However, the risk was mitigated by staff being aware of patients' confidentiality and taking appropriate action to ensure this was respected. The trust were also looking at ways to resolve the issues. The risk was identified on the department's risk register which recorded that the trust was looking to expand or relocate the ECHO department to a different site in the hospital to allow for expansion. However, a date for relocation had not yet been agreed.
- There was a wide range of printed information available to patients and their families and carers, including a range of information leaflets and literature for patients to read about a variety of conditions and support services available.
- Staff we spoke with told us there was a lot of focus in team meetings on how services could meet the needs of patients with a learning disability or patients with dementia.
- Staff at the outpatients department told us they supported people with learning disabilities regularly.

Staff said letters could be provided in 'easy read' formats or large print. Staff said if they were aware of a vulnerable adult attending an appointment they would provide any assistance required. Staff gave us an example of escorting people with learning disabilities or visual impairment to the x-ray department.

- There were chairs in the outpatients department that were reserved for patients with limited mobility or problems with transferring from sitting to standing. There were also chairs reserved for vulnerable patients. The chairs were close to the outpatients' reception, lift and exit. There was provision for bariatric patients in the form of chairs in the waiting area and bariatric wheelchairs.
- The cardiology department had a research nurse in frailty.
- Staff told us the trust's accessible communications team could provide printed information in a range of languages upon request.
- Interpreters could be pre-booked for patients that didn't speak English. Staff told us some members of staff also spoke other languages and could be approached to act as an interpreter.
- The nuclear medicine department had an area set aside for patients with complex needs. However, this was a space in a corridor with a curtain and could compromise patients' privacy. This was identified on the department's risk register.
- Hospital accommodation was available for patients that lived at a distance from the hospital.
- Harefield Hospital had a multi-faith room. Staff told us all faiths could use the room.

Learning from complaints and concerns

- We asked staff on wards and other areas we visited about complaints and they said there were relatively few. Staff told us they spoke with patients regularly to prevent any concerns that patients or families had from escalating. There was a formal complaints process for people to use with investigation, and response to the complainant. Complaints information, as well as patient experience information was fed into the trust governance processes and trust board with formal reporting mechanisms. Staff told us most complaints related to car parking followed by waiting in the waiting room.

Outpatients and diagnostic imaging

- There were monthly staff meetings to look at issues that had been raised by patients. For example, outpatients department team meeting minutes dated 17 March 2016 recorded that a complaint from a patient about staff communication had been addressed with staff.
- On the outpatients department the general information board displayed the complaints and compliments procedure.
- Departments we visited had boxes where patients could leave comments or suggestions.
- Information regarding the Patient Advice and Liaison Service (PALS) and how to contact them was displayed in prominent areas in all the departments we visited.
- Staff had access to an easy read complaints policy for people who required information in this format.
- Staff in both the outpatients and diagnostic and imaging departments told us they always tried to address complaints or concerns immediately to see if they could be addressed by the team. If it could not be resolved by the team, staff told us people would be given the contact details of the patient advice and liaison service (PALS). Staff at the outpatients department added that the team did not get many formal complaints.
- Patients' and staff views were actively sought and there was evidence of continuous improvement and development of staff and services.
- Staff knew and understood the vision of the trust. We found that the local managers demonstrated good leadership within the department and the division.
- Outpatients, diagnostics and imaging were part of the Heart division. The service was led by a divisional lead, a clinical services manager, an associate general manager, and a general manager who reported to the board.

Vision and strategy for this service

- Overall, we found that outpatients, diagnostic and imaging departments had local visions, values and strategies.
- Managers said the trust had recognised the need for modern facilities. The new outpatients department was at the forefront of the trust's new strategy. This included a new electronic records system which was due to be rolled out in 2016. Staff told us the strategy for outpatients included the roll out of the trust's new IT system. Managers told us diagnostics and imaging had worked collaboratively on implementing the new strategy. For example, the cath lab was working closely with the trust's IT department to develop a system for putting information from the old electronic records system onto the new system.
- Manager's told us the outpatients department had a new vision, this was to modernise the way the department provided patient care. This included reviewing how the outpatients department "interfaced" with GP's and acute hospitals, and a new IT system that would improve services ability to draw performance and risk management data.
- Staff were expected to demonstrate the core values of the trust of: 'care; respect; inclusiveness'. We saw these behaviours reflected in staff. Staff had been given cards with the trust's vision, "To be the UK's leading specialist centre for heart and lung disease, "some staff showed us their cards when we asked them about the trust's vision and values.
- We saw the trust' nursing strategy 2015-2018 on display in the outpatients office, together with the trust's mission statement and trust vision.

Are outpatient and diagnostic imaging services well-led?

Good



We rated well-led as good because:

- Innovation was encouraged at the hospital. Outpatient and diagnostic services were involved in a range of research projects in partnership with industry.
- Managers had a good knowledge of performance in their areas of responsibility and understood the risks and challenges to the service.
- Managers and clinical leads were visible and approachable.
- There was a system of governance and risk management meetings at both departmental and divisional levels.
- There was an open and honest culture within the service, morale was high and staff felt included by the trust's executive.

Governance, risk management and quality measurement

Outpatients and diagnostic imaging

- There were organisational, divisional, and department flow charts in place that clearly identified the organisations leadership processes and structure. For example, outpatients, diagnostics and imaging were part of the Heart division, the department reported to the clinical services manager who reported to the associate general manager, who reported to the general manager who reported to the board.
- There were monthly clinical governance day where all aspects of clinical governance were shared and discussed, including updating audits. All staff were involved in these, and staff told us they felt well informed about what was happening in the hospital and said they valued the days.
- There were monthly head of division and head of service meetings. Learning from divisional and service level meetings were disseminated to team leads, who disseminated learning from divisional meetings at team meetings.
- The interim director told us the introduction of the new IT system would provide services with the opportunity to have a dashboard to monitor services and make accessing risk management and quality measurement information easier.
- There were department and divisional risk registers in place. The divisional risk register included one risk relating to imaging. However, the outpatients' department and diagnostic imaging risk register contained 11 risks. Actions to address risks were documented. Risks on the register had been reviewed and updated in June 2016.

Leadership of service

- Managers had a good knowledge of performance in their areas of responsibility and they understood the risks and challenges to the service. Diagnostic and imaging services had good systems of governance and leadership. Most of the staff we spoke with told us the executive team were supportive. Managers told us they had confidence in the CEO and the board. Managers said they had accompanied board members on 'executive safety walk arounds'.
- Staff in the outpatients department told us the general manager for the Heart division and the clinical services manager were approachable. One staff member commented, "They know what is happening on the ground and listen." The interim director told us the divisional leads knew their services, "inside and out." For

example, the respiratory and physiology head of service had worked for the trust for 37 years. The matron in the outpatients department had been in post as an interim for less than a year at the time of our visit. However, they had worked for the trust for 29 years.

- Monthly team meetings took place to ensure staff received information and feedback regarding incidents and complaints and were kept informed of developments within the trust. Staff felt supported and valued in their role and told us the executive team were responsive to new ideas and innovation. There were monthly divisional performance meetings that were attended by department leads. There was a CEO forum which staff took turns to attend and report back to their teams. This helped maintain effective communication between the board and staff.

Culture within the service

- Staff morale was good across outpatients, diagnostic and imaging departments.
- Staff told us they were consulted on how they felt and what they would like to change.
- The chief executive had an open door policy allowing staff to make their thoughts and opinions known. There were mechanisms in place for whistleblowing.
- The outpatients department and diagnostic and imaging departments had introduced, 'What you said; What we did' boards. These informed patients of actions the department had taken to improve services in response to patients' suggestions or concerns. For example, the department of respiratory and physiology had created a map of the facility to enable patients to navigate their way.
- All the staff we spoke with were positive about services and felt positive about their role and contribution to this.
- Staff told us a culture of reporting incidents and concerns was encouraged. The electronic incident reporting system prompted staff to record whether Duty of Candour (DoC) requirements had been fulfilled.
- We observed good team working in all the departments we visited.
- Staff at a focus group told us a strength at the trust was staff having a "can do" attitude. Staff said the hospitals model was not based on 'silos', but was a collaborative approach.

Public engagement

Outpatients and diagnostic imaging

- Staff told us current and ex-patients advised the trust on patient leaflets. Staff said some patients were involved with the hospital for a long time and happy to engage with the hospital. We saw patient information boards in the outpatients department and in the clinical research facility carried posters for voluntary patient representatives.
- Diagnostics and imaging had undertaken an audit of patient feedback in January 2016. We viewed comments from the questionnaire and found these to be universally positive about the services.
- Harefield Hospital imaging department had patient champions. These were volunteers who worked with the department in improving patient experience.
- There were a number of peer support groups patients could engage with. This included a group “Sparks” for patients with implantable cardioverter defibrillators (ICD); these are devices for people with abnormal heart rhythms.
- We saw copies of the trust six monthly magazine, ‘News Beat’, was available in waiting rooms. This carried information on how patients or the public could volunteer for the trust.
- The trust had six monthly awards ceremonies where staff who had gone, “above and beyond”, in their roles were honoured.
- Staff with over 20 years’ service to the trust were invited to a trust centenary luncheon and given a long service badge. We saw some staff wearing their badges.
- Staff told us they had access to independent and confidential counselling and support services.
- We viewed the staff survey ‘frequency report’ for the imaging department. 50% of staff agreed with the statement, “My immediate manager values my work,” and 75% of staff strongly agreed with the statement

Innovation, improvement and sustainability

- The general outpatients department had recently expanded diabetes clinics, as well as the number of nurse led clinics.
- Radiology staff told us about the service developing novel approaches to using MRI scans with the objective of reducing the amount of radiology patients received.
- Staff said innovation was encouraged at the hospital. Examples we were given included an inherited cardiac condition service and the diagnostic and imaging ‘one stop shop,’ this enabled patients to have all their imaging needs met in one hospital visit.
- The imaging department was developing a voice recognition radiation monitoring unit with a private company, this would involve voice activated software (VAS).

Staff engagement

- Staff were well established. Most staff lived locally and told us Harefield Hospital was a “friendly” place to work.
- We observed that morale was high and staff were proud to work at the hospital. A typical comment was, “It’s friendly and supportive.”
- There were divisional ‘away days’ that staff could attend for training and to discuss divisional issues.

Outstanding practice and areas for improvement

Outstanding practice

Outpatients and Diagnostic Imaging

- Diagnostic and imaging services provided a number of examples of outstanding practice, including the imaging department's expertise in a range of inflammatory respiratory diseases including amongst others asthma, allergy, COPD, cystic fibrosis, idiopathic pulmonary fibrosis, and acute lung injury.
- The imaging department's research included exhaled inflammatory biomarkers, skeletal muscle biopsies, imaging, extensive lung physiology techniques, nasal and bronchoscopic sampling, bronchial challenges, as well as a large range of preclinical techniques including models of asthma and COPD.

Surgery

- The Harefield transplant team pioneered the Organ Care System in cardiothoracic transplantation. This is a method for transporting and optimising potential donor hearts. Most other cardiothoracic transplant services have adopted this system. A lung transplant version has also been utilised.
- VAD team members were some of the most highly skilled in the UK. They could care for patients undergoing surgery for the insertion of an artificial heart without the need for the company who make the heart being present. No other service in the UK can provide this without the company being present.
- Patients undergoing surgery at the Harefield hospital had excellent outcomes for cardiac, thoracic and cardiothoracic transplant (heart, lung and heart-lung transplant).

Areas for improvement

Action the hospital SHOULD take to improve End of Life Care

- Ensure ward nurses should undergo regular syringe driver update training to maintain their competence.
- Audit the use of opioids within palliative care as per Nice Quality Standard CG140
- Provide formal training to staff so that they feel confident in recognising patients in the last stages of life and they are able to provide the care that they require.
- Ensure nursing staff within the specialist team are up to date with their mandatory training.
- Ensure PALs officers are given full role specific training rather than relying on previous work experience.
- Provide consultant cover seven days a week, face to face for palliative care patients as per national professional guidance.
- Use a valid assessment tool to document patients care at the end of their life to ensure compliance and consistency.
- Improve their data collection process so that relevant data is easily accessible to improve patient care.

- Flag patients with learning difficulties or dementia within their electronic records systems so that staff are immediately aware of a patients extra needs.
- Record the number of people that died at their preferred place of death for audit and improvement purposes.
- Continue to record end of life care complaints separately to enable learning and changes to take place. This was a new process.
- Meet all national KPI's as set out in the national audit for end of life care so that it can compare and improve itself and encourage development and change. The trust should consider introducing a lay member to the trust board with responsibility for EOLC, in addition to the lay member who attends the EOLC steering group.

Outpatients and Diagnostic Imaging

- Ensure all clinics start at their published time, and consultants do not accept work commitments inside the hours specified in their job plans.
- Reduce the time patients spend waiting in the outpatients waiting room.

Critical Care

Outstanding practice and areas for improvement

- Follow up on concerns around inconsistencies in patient observation scoring including the visual infusion phlebitis (VIP) score and scores relating to confusion and delirium.
- Ensure that staff are appropriately and consistently managing risks associated with venous thromboembolism (VTE) in all critical care wards.
- Ensure there is consultant intensivist cover in all critical care wards including HDU at weekends in line with the Faculty of Intensive Care Medicine (FICM) guidance on medical staffing.

Surgery

- Ensure staff complete the WHO checklist in its entirety and that staff are present for all five steps of the checklist process.
- Ensure surgical staff are completing patients observational NEWS charts fully and escalating unwell patients as a matter of urgency.

- Should follow up on concerns around the culture in relationships between senior surgical staff and their colleagues.
- Ensure staff are trained in understanding the sepsis six pathway and responding to septic patients.
- Ensure that it is meeting the national indicator for cardiac surgery referral to treatment time.

Medicine

- Ensure that hand gel is clearly indicated at the entrance to the wards/clinical areas.
- Ensure that hand hygiene in the cath lab's meets the trust's target of 90% for medical staff and allied health professionals.
- Ensure that mandatory training meets the trusts target of 75% for medical staff and allied health professionals.

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The trust is failing to comply with this regulation because it is not assessing the risks to the health and safety of service users receiving the care or treatment, or doing all that is reasonably practicable to mitigate such risks.</p> <p>National Early Warning Score (NEWS) charts were not always used appropriately to guide escalation.</p> <p>The World Health Organisation (WHO) five steps to safer surgery checklist was not fully embedded.</p>
Regulated activity	Regulation
Diagnostic and screening procedures Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment</p> <p>The trust is failing to comply with this regulation because it is not consistently assessing the risk of, and preventing, detecting and controlling the spread of, infections, including those that are healthcare associated.</p> <p>Systems, processes and standard operating procedures were not always reliable or appropriate to ensure cleanliness and safety of equipment and the environment in theatres.</p> <p>There were failures in infection control practices. This included variable hand hygiene audit results, inconsistent nurse practice and inadequate handling of intravenous fluids.</p>