London North West Healthcare NHS Trust

Ealing Hospital

Quality Report

Ealing Hospital
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Date of inspection visit: 19 - 23 October 2015; unannounced inspections between 3 - 7 November 2015
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This report describes our judgement of the quality of care at this hospital. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

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

Summary of findings

Letter from the Chief Inspector of Hospitals

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

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

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

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

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

Overall we rated this hospital as requires improvement. We rated critical care, end of life care and outpatients and diagnostic services as good. We rated the following acute services provided by the hospital as requires improvement: Urgent and emergency care, medical care including care of the elderly, surgery, and services for children. and end of life care.

Our key findings were as follows:

- The merger of the trust had been protracted and subject to delay. This had had a negative effect on performance and leadership.
- We saw overall disappointing progress in merging systems and processes at the trust. To most intents and purposes Ealing and Northwick Park appeared to be operating as separate entities and community health services appeared disengaged from the rest of the trust.
- There appeared to be substantial duplication of support functions at both main sites. There appeared to have been lack of control over spend of administrative, non-staff, and nursing staffing budgets with little rationale over nursing numbers on wards.
- A new chief executive had recently been appointed earlier in 2015. She was in the process of building a new executive team and by the time of our inspection only one member of the previous substantive executive team was in post. This meant that the new executive team were in the process of getting to grips with their respective functions.
- All staff working at the hospital were dedicated, caring and supportive of each other within their ward and locality. There was a high degree of anxiety and uncertainty borne out of the merger and also fears of service removal and potential job losses particularly at Ealing Hospital.

  • There appeared to be a lack of firm information provided to staff about the effects of Shaping a Healthier Future - to reconfigure services in north west London - despite the chief executive holding regular briefing session. This added to staff anxieties, particularly at Ealing.

- We saw several areas of good practice or progress including:

- a good service overall for end of life care particularly at Ealing and in the community health service.
- caring attitudes, dedication and good multi-disciplinary teamwork of clinical staff.

Summary of findings

- good partnership working between urgent and emergency care staff and London Ambulance staff.
- good induction training for junior doctors.
- research projects into falls bundles, stroke trials and good cross site working in research.
- Staff told us there were good opportunities for training and career development.
- We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner.
- The play specialists in services for children demonstrated how they could make a difference to the service and its environment in meeting the needs of the children and young people. This included an outstanding diversional therapy approach for children and young people, which was led by the play specialist and school tutor.
- evidence of good antibiotic stewardship, particularly at Ealing pharmacy, with regular reviews of need; and the roll out of drug cabinets across certain parts of the trust with secure finger print access.
- patient satisfaction data collected by iPAD by Ealing pharmacy.

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

- The performance dashboards for ED showed that compliance with achieving the mandatory targets, including the 4 hour treatment target, had been poor over the previous 12 months. Performance at Ealing had dropped since the merger.
- The emergency department participated and performed poorly in the College of Emergency Medicine audits on pain relief, renal colic, fractured neck of femur and consultant sign-off; and there were no clear action plans drawn up by the department indicating what actions were taken as a result of the audits.
- Compliance with safeguarding training was poor particularly among medical and dental staff.
- The trust target was to have 95% of staff having completed mandatory training. Trust data, as of March 2014 – July 2015, showed compliance with the target was poor in many areas.
- We saw examples of poor infection control practice such as linen left on a bin when a nurse was putting gloves on, staff wearing nose rings and hooped earrings that were not covered and name badges that were made of paper.
- In surgery, several groups of patients had no formally defined pathway, which impacted on their safety.
- The National Bowel Cancer Audit for 2014 indicated that data completeness for patients having major surgery was poor at 30%, compared with an England average of 87%.
- There was a lack of formal escalation process for surgical patients who deteriorated on eHDU aside from the support provided by the outreach team.
- Staff on wards outside of the end of life team had a poor understanding of end of life care and the trust LDLCA - Last days of life care agreement. Concern was raised that doctors and nurses on the wards did not recognise deteriorating and dying patients.
- Signage for outpatient clinics was in some cases poor and or stopped short of providing clear directions for patients.
- At Ealing ED we had some concerns around the care and treatment of children. There were insufficient children's nurses employed to ensure they were consistently available at all times. Not all adult-trained staff had been trained in paediatric life support.
  - There were some aspects of poor morale of staff on the medical wards at Ealing.
  - There were some concerns with cleanliness and the state of repair or servicing of equipment and fixtures on medical wards at Ealing.
  - Audits showed hand hygiene was a concern with some wards either not submitting audits or scoring less than 90%.
- We had concerns with medicines given by night staff. Drug rounds were arranged so night staff had a round at the start and two at the end of their shift with a potential increased risk of error.
- All types of therapy visits on wards were unscheduled meaning patients could miss their therapy if they were away from their bed or in pain.

Summary of findings

- We were concerned at the lack of provision for dementia care and inconsistent assessment of patients failing to direct them to a dementia friendly wards at Ealing. However, patients living with dementia were not specifically triaged to be admitted to this ward and some aspects of the ward were not dementia friendly.
- In surgery at Ealing there was inadequate stock of some “bread and butter” items of equipment, such as endoscopic gastro-intestinal cartridges. Sets came back from the decontamination unit incomplete.
- At Ealing OPD, the outpatients risk register identified five issues of concern including lack of capacity, temperature in the women’s clinic environment, lack of availability of complete medical records, overbooking clinics and absence of a dedicated plaster sink in the plaster room.
- Trust wide there were temperature control issues across sites in rooms where medicines are stored.
- The above list is not exhaustive and the trust should address these and the rest of the issues outlined in our reports in its action plan.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	The percentage of patients seen within 4 hours was better than the England average before the merger with the London North West Healthcare and has since fallen to worse than the England average and the 95% standard set by the Department of Health. It fell sharply in December 2014 to 81% and has since moved up to 90% from April 2015 but was still below the England average. We had some concerns around the care and treatment of children. There were insufficient children's nurses employed to ensure they were consistently available at all times. Not all adult-trained staff had been trained in paediatric life support. The department had not performed well in national audits by the College of Emergency Medicine that measured performance against best practice and good clinical outcomes. Consultant sign-off, renal colic, fractured neck of femur, severe sepsis and septic shock were all areas of concern. We could see no clear plan of action to address this poor performance. Unplanned re-attendance rates (within 7 days) reduced in January 2014, but remained worse than the England average and the required standard from January 2013 – February 2015. We reviewed staff training records and noted that all staff had received mandatory training, including safeguarding adults and children. Mental capacity assessments were being undertaken appropriately and staff demonstrated knowledge around the trust's policy and procedures with regards to mental capacity and deprivation of liberty safeguards. Staff took the time to listen to patients and explain to them what was wrong and any treatment required. Patients and relatives told us that they had all their questions answered and felt involved in making decisions about their care and treatment. Patients were treated with compassion and respect throughout their stay in the accident and emergency. Staff made sure patients were involved in discussions about their care and understood what was happening to them.

Summary of findings

			We found there was good clinical leadership and that staff continued to work well as a team and were motivated and positive about working for the department. Staff were well supported by clinical leads and local senior management. However the corporate leadership were not visible and less supportive of staff.
Medical care (including older people's care)	**Requires improvement**		Medical services required improvement at EH in safety, effectiveness, responsiveness and leadership. We were particularly concerned about the sustainability of already stretched staffing levels when a new ward will be opened at Northwick Park which some recently appointed staff will be allocated to. Patient records were not complete or patient focused in a number of instances. There was some over reliance on junior staff and there was a lack of cross site governance and working. Discharges were constantly delayed and patients were not always cared for on the correct ward. There was a lack of support and communication from divisional level. However we found caring was good overall with positive patient feedback and improving friends and family test scores. Incidents were mostly learnt from although only if they occurred locally. There was awareness of the Mental Capacity Act and pain relief was well managed. There was good patient flow through the AMU and complaints were learnt from. There was support from local leadership and some performance oversight.
Surgery	**Requires improvement**		Patient safety checks in the Endoscopy department were not taking place using the World Health Organization (WHO) Surgical Safety Checklist. In addition the arrangements related to surgical instrumentation and availability of technical equipment was not always optimised. Staff had a good knowledge of the issues around capacity and consent but there was lack of assurance that staff had received Mental Capacity or Deprivation of Liberty Safeguard training.

Summary of findings

The surgical risk register did not always identify the specific location the risk related to and dates for resolution of risks had not always been stated.
The recovery area within theatres was not able to cope with the level of activity. Furthermore, the area used by children had not been designed or planned to take into account their needs.
Referral to treatment times were not being met in some surgical specialties. Theatres were not always effectively utilised and operating sessions started and finished later than planned, which impacted on patient discharges.
Staff reported positively on their immediate line managers and demonstrated a commitment to the delivery of high quality patient care. Despite this, staff had been affected by recent changes following the merger of locations and were struggling to understand the future direction of the service at the location.
The environment in surgical services had not been developed to address the needs of individuals living with dementia.
Where complaints were raised, these were investigated and responded to and where improvements were identified, these were communicated to staff. The governance arrangements facilitated the monitoring of risks, safety, patient outcomes and effectiveness of the service and information was communicated across all levels.

Critical care

Good

Overall the critical care at Ealing was good. Patients were cared for by a safe number of competent staff who used evidence-based practice to achieve good outcomes. Staff had good access to patient information and current best practice guidelines as well as up to date research articles. Patient safety thermometer results were good and there was a proactive incident reporting culture.
We saw evidence that incidents were investigated appropriately, with learning points disseminated to unit staff,. hHowever, there was limited shared learning relating to incidents. The vision for the service focused on an improvement in quality and safety through investment in staff training and development.

Summary of findings

We saw some evidence of innovation such as the development of the high flow oxygen service.
The critical care service was caring and patient privacy and dignity was maintained at all times.
Staff knowledge and implementation of safeguarding was good and we saw evidence that regular patient risk assessments took place.
Patients' pain was frequently assessed and well managed by staff who ensured patient comfort at all times.
Multidisciplinary working was embedded on the unit, particularly during the weekly meeting.

Services for children and young people

Requires improvement

Children and young people's services overall requires improvement but the service is considered good for caring. We found out of date policies still in use, Control of Substances Hazardous to Health (COSHH) assessments not completed and chemicals found stored in an unlocked cupboard in an unlocked cleaning room in the children's ward.
There were notable staff shortages in some areas with a high use of agency or bank staff covering for sickness and additional leave. Senior staff had to seek out patients when children were admitted to an adult bed, as there was no flagging system. There were gaps in support arrangements for children with long term conditions e.g. epilepsy and no identified nurse specialist to support this group of patients.
The service was not responsive to meeting the needs of children and young people when in the children's accident and emergency department as the waiting time was reported as too long by parents seen. The children's waiting times data was requested from the trust but not received.
We were informed of the future change for the service which had been developed. Eight staff were spoken to by the inspectors of which two staff members were not aware of the local or trust strategy.
The arrangements for governance and performance management did not always work effectively as items on the risk register did not reflect all the areas that require improvement.
Leadership within the service was rated as requiring improvement. Staff informed us that managers had not always been visible on this site since the movement of managers to the Northwick Park site.

Summary of findings

End of life care

Good

We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner. However there were some concerns raised by specialist staff and from our observations about whether all generalist nurses, doctors and consultants had the expertise to recognise patients who were dying.

The knowledge base was described as “patchy” especially since the withdrawal of EOL and specialist palliative care induction training which had given all staff a base knowledge and understanding.

We were given examples of patients’ treatment and observations continuing when EOL had been identified. This could cause the patient unnecessary pain and discomfort at a time when these actions would make no difference to the patient’s health and wellbeing.

The Last Days of Life Care Agreement which replaced the Liverpool Care Pathway was not being used for any of the patients we reviewed, although ‘do not attempt cardio pulmonary resuscitation’ orders were in place. The completion of DNACPRs was variable. Some were not fully completed or discussed or signed off by a senior clinician.

The SPCT leads were focussed on raising staff awareness around EOLC. However they felt this should be more widely embraced in the trust.

Staff were aware of their responsibility in raising concerns and reporting incidents. However, we found there was apathy in reporting everything including near misses due to a lack of feedback and learning outcomes.

The SPCT at Ealing hospital did not feel engaged with the trust strategy and were unsure how it would affect services at Ealing Hospital.Although the lead for palliative and cancer services visited Ealing Hospital twice a week there was little local leadership on a day-to-day basis.

Outpatients and diagnostic imaging

Good

Overall outpatient and diagnostic services at Ealing Hospital were good because there were systems in place to identify record and review incidents and staff were aware of how incidents should be escalated and recorded.

Summary of findings

Outpatient and diagnostic services were visibly clean and there were processes to ensure cleaning was maintained.
We saw good evidence of how the diagnostic services benchmark their services through national and local audit activity and national guidelines including NICE and Royal College of Radiologists.
We found staff were compassionate, caring and proud to work at Ealing Hospital.
Mandatory training was provided however staff told us face to face training was often difficult to access or attend due to clinical commitments.
Hard copy records were not always available in time for clinics; the trust was aware of this and had started phased plans to integrate hard copy records in preparation for a move to an electronic record management system across all sites.
The service had a backlog of patients waiting more than 18 weeks for an appointment and had attempted to reduce waiting times for patients.
There was a good system in place which highlighted the patients who had waited longest and should be clinically prioritised for the first available appointments.

Ealing Hospital

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to Ealing Hospital

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

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

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

The trust currently does not have foundation trust status.

Ealing Hospital serves an ethnically diverse population mainly in the London Borough of Ealing. The health of people in Ealing is varied compared with the England average. Deprivation is higher than average and about 21.6% (15,300) children live in poverty. It ranks 80th most deprived of 326 local authorities in the country. Life expectancy for both men and women is higher than the England average in the London Borough of Ealing.

Services provided:

Ealing Hospital provides the following inpatient services: general surgery, trauma and orthopaedics, cardiology, gastroenterology, respiratory medicine, infectious diseases, general medicine, urgent and emergency care, critical care, paediatrics, cardiology and obstetrics.

The hospital provides the following outpatient services: anticoagulant services, audiology, breast care, care of the elderly, chest pain, chiropody, clinical haematology, clinical oncology, colposcopy, dermatology, diabetic medicine, dietetics, dressings, endocrinology, ear nose and throat medicine (ENT), gastroenterology, general medicine, general surgery, gynaecology, infectious diseases treatment, maternity scans, neurology, obstetrics, oral surgery, paediatric cardiology, paediatrics, phlebotomy, renal medicine, respiratory medicine, rheumatology, surgical appliances, trauma and orthopaedics, urology and vascular surgery.

Beds and staff employed: The hospital has 358 beds and employs approximately 1620 staff.

There were 102,227 A&E attendances at Ealing Hospital in 2014/15 and 22,012 inpatient admissions in 2014. Between April 2014 and March 2015 there were 216,448 outpatient appointments.

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

Detailed findings

Between August 2014 and July 2015 there was one never event at this location, and 148 serious incidents.

Between April 2013 and March 2014, the trust received 223 complaints relating to Ealing Hospital.

Our inspection team

Our inspection team was led by:

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

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

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

How we carried out this inspection

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

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

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

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

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

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

Facts and data about Ealing Hospital

Safe

• Serious incidents: 148 were reported for Ealing between Aug 2014 and Jul 2015.

• At Ealing the proportion of junior doctors is higher and the proportion of consultants is lower than the England average.

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

Detailed findings

• There were four never events reported between August 2014 and July 2015. 3 in Northwick Park(Medicine x2 and Surgery x1). There was also one in Ealing in the Children's core service. when an eight-week-old baby was given an oral dose of antibiotic intravenously.

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

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

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

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

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

Effective:

Despite a rise in HSMR mortality, the CQC Hospital IM report May 2015 showed no evidence of elevated risk.

Caring:

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

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

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

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

Responsive

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

Well-led

The sickness absence rates at Ealing have been consistently below the England average.

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

Our ratings for this hospital

Our ratings for this hospital are:

Detailed findings

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

Notes

Urgent and emergency services

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

Information about the service

The emergency department (ED) at Ealing hospital (EH) is open 24 hours a day, seven days a week. It treats people with serious and life-threatening emergencies and those with minor injuries that need prompt treatment. The department consists of separate areas including: majors, minors, resuscitation areas, an ambulatory unit, and a clinical decision unit (CDU). In addition, there is a separate paediatric area for children and young people under the age of 16. The resuscitation area has four beds one of which is primarily for children.

Ambulance patients who are unwell and may need admission are assessed and directed through to the majors or minors area depending on their clinical needs. The ambulatory emergency care unit operates from 9am to 6pm, Monday to Friday. This service provides same-day emergency care for patients who were able to be assessed and treated without the need for an overnight admission. The emergency department sees approximately 53,270 patients a year, of which approximately 18% are children.

We visited the service over two days and observed care and treatment and looked at 18 treatment records. During our inspection, we spoke with 12 members of staff, including nurses, consultants, doctors, receptionists, managers, support staff and ambulance crews. We spoke with five patients and two relatives. We received comments at our listening event and from people who contacted us to tell us about their experiences, and we reviewed performance information about the trust.

Summary of findings

The emergency department at Ealing Hospital (EH) required improvement to ensure that services were safe and responsive to the needs of the patients being treated at the hospital.

The percentage of patients seen within 4 hours was better than the England average before the merger with the London North West Healthcare and has since fallen to worse than the England average and the 95% standard set by the Department of Health. It fell sharply in December 2014 to 81% and has since moved up to 90% from April 2015 but was still below the England average. The percentage of patients waiting four to 12 hours before being admitted was better than the England average before the merger in October 2014.

We had some concerns around the care and treatment of children. There were insufficient children's nurses employed to ensure they were consistently available at all times. Not all adult-trained staff had been trained in paediatric life support.

The department had not performed well in national audits by the College of Emergency Medicine that measured performance against best practice and good clinical outcomes. Consultant sign-off, renal colic, fractured neck of femur, severe sepsis and septic shock were all areas of concern. We could see no clear plan of action to address this poor performance.

Urgent and emergency services

Unplanned re-attendance rates (within 7 days) reduced in January 2014, but remained worse than the England average and the required standard from January 2013 – February 2015.

We reviewed staff training records and noted that all staff had received mandatory training, including safeguarding adults and children. Mental capacity assessments were being undertaken appropriately and staff demonstrated knowledge around the trust's policy and procedures with regards to mental capacity and deprivation of liberty safeguards.

Staff took the time to listen to patients and explain to them what was wrong and any treatment required. Patients and relatives told us that they had all their questions answered and reported being involved in making decisions about their care and treatment. Patients were treated with compassion and respect throughout their stay in the accident and emergency. Staff made sure patients were involved in discussions about their care and understood what was happening to them.

We found there was good clinical leadership and that staff continued to work well as a team and were motivated and positive about working for the department. Staff were well supported by clinical leads and local senior management. However the corporate leadership were not visible and less supportive of staff.

Are urgent and emergency services safe?

Requires improvement

Incidents were reported promptly and investigated appropriately. However, we were concerned that lessons learnt were not always fully embedded into practice. We noted that some incidents such as catheter related urinary tract infections (CUTI)'s and pressure ulcers were not routinely reported. This is indicative of a risk that incidents may not be formally reported by the staff.

The supply of suitable monitoring equipment was insufficient within the department.

There was a high use of agency nurses and locum doctors within the department. Most of the temporary staff members were unfamiliar with the department, or the policies and procedures they should work to. We found that patients did not always receive emergency care promptly which could have impacted on their clinical condition and outcome.

Children had appropriate separate facilities within the department. Safeguarding was understood and protocols were followed when required. Staff were aware of the challenges within the department regarding children's service provision, and were working towards addressing those challenges with training and recruitment.

However, we had some concerns around the care and treatment of children. There were insufficient children's nurses employed to ensure they were consistently availability at all times. Not all adult-trained staff had received training in paediatric life support. The department did not have enough doctors and nurses to keep patients safe at all times.

Medicines and records were appropriately managed and infection control procedures were followed.

Incidents

- There was one never event regarding a medicine error in the children's area of the department recorded between April 2014 and July 2015. A child was given an oral medicine through an intravenous route. We saw evidence in the form of an investigation report that the incident was investigated using root cause analysis and lessons learnt were shared with staff at the department.

The investigation followed a proper root cause analysis process with regards to the background of the incident, medical history of the patient and chronology of what happened with identification of contributory factors, root causes and recommendations. Senior nursing staff we spoke with confirmed that, they were provided with information about the incident.

- Nursing staff we spoke with told us they knew how to report an incident using the Datix Incident Reporting System. They said they had reported incidents frequently and had received feedback on the incidents they had reported.
- The department had not reported any pressure ulcers, falls with harm or catheter related urinary tract infections (CUTI's) between June 2014 and June 2015. However, some nurses we spoke with told us they had frequently reported pressure ulcers and UTI's, which had not been recorded formally by the department.
- We were told that learning from incidents and 'near misses' were shared with staff via emails and team days. However, we did not see any evidence to support this and most of the staff we spoke with were not able to show us any emails as such. There was some information about the department and teaching programs clearly displayed on a noticeboard in the staff room.
- We noted that managers and senior staff had a good understanding of Duty of Candour and had attended relevant training about their responsibilities in disclosing to patients when an incident that could cause harm had occurred.

Cleanliness, infection control and hygiene

- The department was clean and staff were aware of the current infection prevention and control guidelines. We observed support staff cleaning the department throughout the day.
- We looked at the department's hand hygiene audit results and saw it had achieved 93% compliance from April 2015 to date.
- Sluices were clean and well organised, and clinical waste was handled and disposed of safely. Audits showed hand hygiene scored over 95%. All the staff observed appropriate infection prevention and control guidelines such as bear below the elbow, wearing personal protective equipment and washing hands between patient interactions.
- Adequate hand washing facilities and alcohol gel were available throughout the department. We observed infection control practices, such as staff following hand hygiene practices, 'bare below the elbow' guidance, and wearing personal protective equipment such as gloves and aprons as appropriate.
- Equipment, including patient trolleys, were clean and cubicles were cleaned and labelled as been cleaned. Cleaning staff we spoke with confirmed that there was an escalation process in place when extra cleaning staff were required.

Environment and equipment

- The supply of suitable monitoring equipment was insufficient within the department. We noted that only one monitored bed was available. This meant patients might not be able to be monitored in time when needed and unable to receive safe care and treatment when the monitored bed is occupied.
- We found that regular checks had been completed on key equipment, such as echocardiogram (ECG)machines, to ensure that they were working.
- We checked the resuscitation trolleys and found them to be correctly stocked and maintained. They were appropriately checked at each shift change with records kept to show the checks took place.
- There was a safe and effective system in place for the repair and maintenance of equipment. The staff were aware of the process for obtaining medical equipment and what to do where the equipment was found to be in need of repairs.
- We found potential ligature points in the mental health place of safety room in Ealing ED and brought this to the attention of the nurse in charge who immediately contacted the estates department to investigate. We have asked the trust to review all of the equivalent facilities at its remaining locations including those we did not inspect on this occasion.

Medicines

- Medicines were stored, managed, administered and recorded safely and appropriately. Training data for the department showed that nursing staff had received training in medicines management.

- Nursing staff recorded fridge temperatures daily in all the areas of the ED we visited. We did not find evidence that the fridge was operated with temperatures out of the expected range.
- We checked medicine records and stocks of medicine, including controlled drugs. We found these to be correct, detailing appropriate daily checks been carried out by qualified staff as required.
- During the inspection, we looked at 18 sets of patients notes and, in particular, drug prescription charts. We found all drug prescription charts fully completed, with appropriate doctor's signature.
- We looked at patient prescription charts, which were completed and signed by the prescriber and by the nurse administering the medicine.

Records

- The department had its own patient assessment record, which included the patient's personal details, previous admissions, alerts for allergies, patient's weight and observations charts.
- Patient records were a mixture of electronic and paper record.The completion of paper records was done with a variable degree of completeness. We reviewed 18 patients' records, and some of the issues uncovered were lack of pressure area assessments, and no documented evidence of patients being seen within an hour. However, all of them were signed and dated by both medical and nursing staff.
- Medical and nursing records were kept together in a single set of patient notes, which were kept securely in a trolley by the nursing station. We found that, in the records we reviewed, initial clinical observations, such as blood pressure, pulse, respiration and temperature checks were recorded on all patients who attended the department.

Safeguarding

- Staff we spoke with had a good understanding of safeguarding concerns for adults and children. Access to information on how to report a concern was available and displayed on boards in the department.
- All staff (including administrative staff) were expected to complete level two child protection training and senior clinical staff were expected to complete level three training. At the time of our inspection, 84% of ED staff had completed mandatory training in level two adult safeguarding and 79% had completed children's safeguarding level two and 60% had completed level three training against the trust target of 95%. We were not told of any specific plans to increase this at the time of our inspection.
- Staff that we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood the safeguarding procedures that were in place and how to report concerns. We did not see any safeguarding referrals made during our inspection.

Mandatory training

- Mandatory training included essential topics such as fire training, health and safety, infection control basic life support and manual handling. We examined the training records for the department and found 85% of staff were up to date with their mandatory training.
- Mandatory training was provided in different formats, including face-to-face classroom training and e-learning (e-learning is electronic learning via a computer system), although staff told us that there was limited time allowed to complete e-learning. This meant that sometimes they had to complete the e-learning in their own time.
- We were told that the target uptake for each mandatory training topic was different and this sometimes led to confusion when assessing the completion of individual mandatory training against trust targets. We did not see evidence of mandatory training provided for and completed by agency staff including induction training.

Assessing and responding to patient risk

- The department operated a triage system of patients presenting to the department either by themselves or via ambulance. These patients were seen in priority order depending on their condition. During our inspection, we tracked a small sample of patients and found that they were seen by a clinician within 15 minutes of arrival into the department.
- Patients who walked into the department or who were brought by friends or family were directed to a receptionist. Once initial details had been taken, the patients were then assessed by a triage nurse to determine where the patient was to be sent for further treatment. If a patient was identified as needing urgent and more intensive intervention, they were transferred

through to the majors or resuscitation area where appropriate care and treatment was provided. Patients requiring non-urgent care were signposted to the urgent care centre operated by a different provider.

- Patients arriving as a priority blue light call were transferred immediately through to the resuscitation area. Such calls were phoned through in advance by the London Ambulance crew, so that an appropriate team were alerted and prepared for the patient's arrival.
- We found that the department used a recognised national early warning score (NEWS) to assess patients and identify if their condition was deteriorating. Staff we spoke with were aware of the process and made frequent records of patients' vital signs. We examined 18 sets of notes and found that all of them had appropriately completed NEWS monitoring forms.
- Doctors we spoke with told us that they were appropriately called by nursing staff to see deteriorating patients as necessary.
- Staff knew how to escalate key risks that could impact on patient safety, such as staffing and bed capacity issues. There was an escalation policy in place and daily involvement by bed managers and the matron to address capacity issues that impacted on patient care.

Nursing staffing

- Evidence provided by the trust indicated that the department was not operating at the required whole time equivalent posts (WTE) for nursing staff, with over a 37% vacancy rate as of August 2015. The vacancies were filled using bank and agency staff. We did not see evidence that the department, at the time of our inspection, was using a recognised acuity or staffing tool to determine its establishment of nursing posts.
- We did not see evidence that staff shortages were escalated on a day to day risk basis. However we were told by the matron that two new band five nurses were recently recruited and had since started working in the department. The service was also in the process of recruiting additional band six and band seven nurses to support the workforce of the department.
- Band seven staff nurses were usually in charge of the department and were usually supported by the matron who was on duty Monday – Friday from 9am – 5pm.
- The children's ED operated three shift patterns (early, late and night). Only one paediatric qualified nurse was rostered on duty at any given time in the children's ED. They were supported by a health care assistant (HCA) at all times. Royal College of Nursing guidance states that the department should have two paediatric nurses on duty at all times. Staff told us that sometimes they could not get a paediatric nurse so they would use adult ED nurses who had some experience in paediatrics.
- Nursing staff told us that when a child attended the department, appropriate staff from the children's ward would attend if there was no paediatric nurse in the department.
- An ED education facilitator, who also worked clinically, supported nursing staff at the ED. This role coordinated the activities of nurses within the department and helped to develop competency assessments for nursing staff.
- **Medical staffing**
- The department employed 28 WTE medical staff, 17% of which were consultants, 53% were registrars, 4% were middle grade and 25% junior grade doctors. The department had 25% medical staffing vacancy rate and relied heavily on the use of locum medical staff.
- The department had a lower percentage of consultants, registrar's and middle grade doctors, when compared to the England average, and had a similar percentage to the England average of junior doctors. Consultant cover was below College of Emergency Medicine recommendations and was listed on the trust risk register as insufficient to provide 24 hour cover resulting in a reduced consultant led service. The mitigation action plan was to continue a consultant recruitment campaign.
- Middle and junior grade doctors were on duty 24 hours a day in the department. We spoke with junior and middle grade doctors who spoke positively about working in the department. They told us that in-house teaching was well organised and comprehensive and their consultants were supportive and approachable.
- A consultant was present in the department from 8am until 10pm Monday to Friday. There were middle-grade doctors and junior doctors overnight with a consultant on site from 8am to 11am at the weekend plus an on-call consultant system during the rest of the weekend and out of hours.
- We saw consultants working in the department, and observed positive interactions between the consultants

and other clinical staff working in the department. The consultants were included in the team handovers with the nurses and junior doctors to ensure the consultant in charge was aware of each patient in the department.
- The department consistently relied on locum middle grade doctors. When we reviewed the rota, we noted that the same doctors were consistently in use.

Major incident awareness and training

- The trust had a documented major incident and business continuity plan, which listed key risks that could affect the provision of care and treatment. The major incident plan provided clinical guidance and support to staff on treating patients of all age groups and included information on the triaging and management of patients suffering a range of injuries, including those caused by burns or blasts and chemical contamination.
- Guidance for staff in the event of a major incident was available within the trust's major incident plan, which was also located in the department.
- Staff in the ED were well briefed and prepared for a major incident and could describe the processes and triggers for escalation. Similarly, they described the arrangements to deal with casualties contaminated with chemical, biological or radiological material or hazardous materials and items.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The department participated in the College of Emergency Medicine (CEM) audits; however there were no clear action plans to indicate the improvements needed as a result of the audits were acted upon. Pain relief was offered appropriately in most cases, and its effectiveness was assessed and acted upon as shown by the CEM audits.

Policies and procedures were developed in line with the national guidance and best practice evidence from professional bodies such as the Royal College of Emergency Medicine, the National Institute for Health and Care Excellence (NICE) and the Resuscitation Council UK, however some of the paper based policies in the resuscitation department folders we saw were out of date.

There was some evidence of adherence to national guidance to provide evidence-based care and treatment for patients. Patients were triaged as they entered the emergency department.

Departmental records showed that nearly all nursing staff had received appraisals. Staff were well supported, with good access to training, supervision and development. We saw effective collaboration and communication among all members of the multidisciplinary team and services were geared to run seven days a week.

Clinical audit activity was stronger in the department because a consultant had been able to take specific responsibility for assessing the effectiveness of treatment delivered in the emergency department (ED).

Evidence-based care and treatment

- The department used a combination of National Institute of Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines for patients care. Guidance was regularly discussed at governance meetings, disseminated to staff during team days.
- A range of clinical care pathways had been developed in accordance with recognised guidance for example, stroke, pneumonia, fractured neck of femur sepsis, renal colic and head injury. The department audited compliance with these pathways regularly. Ambulatory care pathways were also in place and followed by staff.
- The patient clinical assessment record reflected evidence-based guidance for effective risk assessment and included tools for assessing patient risks such as sepsis so that if the patient's condition deteriorated, medical staff could be alerted quickly.
- A consultant within the department took the role of audit lead. Junior doctors participated in departmental audit activity. The next planned audit was in pain management in ED in adults and children (as two separate audits) to be started in January 2016. The results and actions arising from the audits were presented in the clinical governance committee meetings, which was held monthly at the trust.

- The hospital did not have specialist doctors for key areas such as maternity, obstetrics and gynaecology due to the closure of the maternity unit. This meant doctors working in ED had to deal with these conditions themselves rather than being able to ask a specialist doctor to attend the patient. Doctors we spoke with told us that in exceptional circumstances, they could seek assistance from their colleagues in Northwick Park Hospital. There were no pathway or treating criteria for the patients. Patients were stabilised and either sent home with an appointment at the Northwick Park Hospital or a GP follow up appointment.

Pain relief

- We spoke with 17 patients and some of them had been in pain during their attendance. They all told us that they had been given pain relief very soon after arriving at the hospital. Staff we spoke with were aware of the appropriate guidance on providing pain relief to patients.
- Pain assessment charts were used for recording feedback from patients on the level of their pain. We examined 18 sets of patient notes and in only one of them we found that a pain chart had not been completed.
- The department had participated in the national College of Emergency Medicine (CEM) audit in 2013 – 2014 for renal colic and fractured neck of femur, which assessed patient's experience of pain relief. The audits showed areas for improvement in consultant sign-off, fractured neck of femur, renal colic and sepsis. However, the hospital had not developed an action plan to address the findings of the CEM audits.

Nutrition and hydration

- The department undertook regular food and drink rounds 24 hours a day, seven days a week. Patients had also been provided with soup. However, we noted that patients were not being provided with hot food due to recent changes of catering contract. The new catering team had decided that it was against Health and Safety legislation to provide hot food from the existing kitchen. A business case was made by the department to upgrade the existing kitchen to be compliant with the health and safety legislation and the business case was declined by trust management. Patients who were unable to eat or drink were prescribed intravenous infusion.

Patient outcomes

- The department participated in national College of Emergency Medicine (CEM) audits so that they could benchmark their practice and performance against best practice in other emergency departments. The CEM audits included consultant sign off, renal colic, fractured neck of femur and severe sepsis and septic shock.
- The majority of the CEM audit results were worse than the national average, such as consultant sign-off. The standard states that three types of patients groups should be reviewed by a consultant prior to discharge. These were adults with non-traumatic chest pain, febrile children less than one year old and patients making an unscheduled return to the ED with the same condition within 72 hours of discharge. The department performed worse than the UK average in all the eight measures as they achieved an average of 2% against the UK average of 14%.
- In the Renal Colic audit by the College of Emergency Medicine in 2013, the target was that 98% of patients in severe pain should be provided with analgesia within one hour of arrival in ED. The department achieved 65%. This meant that 33% of the patients did not received analgesia within one hour of their arrival in the department.
- The unplanned re-attendance rate to A&E was consistently worse than the 5% target and the England average from January 2013 – February 2015.The average score for the department was 13%. This was an indication that patients were possibly being discharged inappropriately by the department.
- We looked at audit results and saw that they had not been reviewed by managers and priorities for improvement had not been identified. Most of the clinical staff we spoke with were not aware of these audits or the department's results of the audit. We could not see any evidence that the results of the audit had been used to improve the effectiveness of care. There was a lack of action plans which addressed the findings of audits in order to improve services.

Competent staff

- The department was not compliant with nursing and clinical staffing guidance published by The Intercollegiate Standards for Children and Young People in Emergency Care Settings. This required nurses working in the children's ED to have a minimum level of

knowledge, skills and competence in both emergency nursing skills for the care of children and young people For example, they had not been trained in recognition of serious illness and identification of vulnerable patients at the time of the inspection. Some of these nurses mostly worked on their own without the supervision of the registered children's nurse.

- The children's ED had four paediatric nurses in post, and only three were in active service, and the other one was on maternity leave. There was only one paediatric nurse on duty at any given shift at the department.
- Not all the paediatric nurses had received training in Advanced Paediatric Life Support, and there was no guarantee that the paediatric nurse on duty had this level of training. This created a potential risk to children in the event of an emergency.
- We saw evidence of development programmes for different grades of nurses. There were two new band five staff nurses and they all worked as supernumerary members of staff for a designated period of time. During this supernumerary period they had to have specific competencies signed off by a senior nurse before being able to care for ED patients independently. They showed us evidence of their competency training.
- Medical and nursing staff we spoke with told us they were well supported with weekly training sessions. The department had a nurse educator who provided training and support to staff. Staff were positive about the input of the nurse educator and found their role very good. However we didn't see any evidence of the training they provided to staff.
- Newly qualified nurses we spoke with had assessments to check their competency in key areas of staff nurse's role including ED competencies such as drug administration, drug calculations, and setting up of intravenous infusion. All nursing staff were required to undertake medicines training and a competency assessment prior to administering medicines unsupervised.
- A housekeeper said they had undertaken induction and mandatory training, including safeguarding, manual handling and infection control. They said they had been able to become involved in hand hygiene audits, infection control and environmental audits to facilitate their development.
- The percentage of nursing staff with completed appraisals in the department was approximately 91% for the year which nearly met the trust's ambitious target of 95%.
- The nursing and medical staff we spoke with were positive about 'on-the-job' learning and development opportunities. Medical staff told us clinical supervision was in place and was non-hierarchical whereby staff could choose their own supervisors.
- We were told that that staff had to undertake corporate induction. However, we saw staff who had started about few weeks previous to our inspection and they had not yet received their corporate induction.

Multidisciplinary working

- There was a mixed relationship between the paediatric department and the local Child and Adolescent Mental Health Service (CAMHS) team who were sometimes unable to conduct an assessment. We were told that in most cases the CAHMS team did not see children within the stipulated timeframe as stated in the trust protocol.
- However we did see that the ED worked closely with the Psychiatric Liaison Team, and they could be contacted easily via bleep or the switchboard when needed.
- There was a clear, professional and joint working relationship between the department and other allied healthcare professionals within other departments, such as radiology, surgery, medicine and physiotherapy.
- Medical and nursing staff we spoke with said there was good multidisciplinary working and support. They said that multidisciplinary team meetings ensured good communication and input of each professional in the care of individual patients. We observed good communication between different professionals and a respect for each other's expertise and input.

Seven-day services

- The ED provided services seven days a week.
- The department had access to radiology support 24 hours each day, with rapid access to computerised tomography (CT) scanning, when indicated. ED consultants were contracted to provide cover 24 hours per day, seven days per week, either directly within the department or on call.

Access to information

- The department had a computer system that provided up-to-date information about a patients' condition and progress within the ED. However, patient information about previous attendances was not available to the triage nurse as the nurse did not have access to the computer system at the triage room. This meant that they did not always have sufficient information to prioritise appropriately.
- Staff could access the trust intranet which allowed ready access to relevant clinical pathways, policies and information.
- Patient investigation results were accessible electronically, including blood tests and imaging reports.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We asked staff about the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards. Staff knowledge was variable and most of the nursing staff said the medical staff were responsible for mental capacity assessments.
- The staff we spoke with had knowledge about consent and mental capacity. However, patients' capacity and any best interests' decisions were not consistently recorded in the patient records we reviewed during the inspection.
- We observed positive interactions between staff, patients and their relatives when seeking verbal consent. The patients we spoke with confirmed their consent had been sought prior to care and treatment being delivered.
- The department's mandatory training database showed staff had undergone safeguarding level two & three, but none had undertaken mental capacity training. Therefore the department could not be assured that mental capacity was being adequately assessed. We observed nursing and medical staff seeking consent from patients before any care or procedure being carried out.

Are urgent and emergency services caring?

Good

The emergency department (ED) provided compassionate care and ensured that patients were treated with dignity and respect. Patients spoke positively about the care and treatment they had received and we observed many positive interactions. Staff provided patients and their families with emotional support and comforted patients who were anxious and kept them informed about their on-going plans and treatment.

Feedback from patients, relatives and carers was generally positive. All the patients and relatives we spoke with during our visits spoke highly of their care and the staff providing it. The response rate to the Friends and Family Test in the department was very encouraging, and the majority of respondents provided positive feedback. There were positive comments from patients about the care received, and the attitude of motivated and considerate staff. They told us they were involved in the decision-making process and had been given clear information about treatment options.

Compassionate care

- The patients we spoke with reported that they received good quality care and support from staff. We observed patient-centred care and saw staff responding respectfully to requests for support, even when they were busy. We observed staff speaking kindly to patients and talking with them in a friendly, dignified and respectful way.
- We observed patient and staff interaction, during which staff demonstrated caring and compassionate attitudes towards patients. Patients told us their privacy, dignity was maintained at all times, and we observed staff pulling curtains around patient areas before completing care tasks.
- Patients and relatives were confident about the care at the department, they told were caring and always did the best they can for them to make sure they were comfortable.
- Staff we spoke with demonstrated an understanding of the need to recognise cultural, social, religious and

individual needs of patients. We noted that staff were respectful and they maintained confidentiality around patients and relatives when communicating with people ensuring that patient's information was protected.

- The Matron told us, the ED participated in the NHS Friends and Family Test (FFT) and consistently scored an average of 65% response rate on a monthly basis, and 94% of the respondents recommended the department to their friends and family. Nursing staff were given incentives on the number of FFT surveys their patients' had completed, this initiative made the department's response to the survey better than the national average of 57%.

Understanding and involvement of patients and those close to them

- We observed staff involving patients and their families in their treatment and care. Staff involved patients and their relatives about discharge arrangements and asked them if they were happy with the plan put in place.
- Most of the patients we spoke with told us that they were informed about their care at the department. They said staff dealt with their needs quickly and were polite when speaking to them. We observed staff explaining to patients if there was going to be a delay in seeing a doctor, the reason for the delay, and how long they would have to wait to be seen. Patients told us all the staff explained the condition and progress in a way they understood, and all interventions were explained to them before it was conducted.
- Parents accompanying their children in the Children's ED were positive about the treatment their child received. They said that the nurses and doctors were supportive and understanding.

Emotional support

- The hospital had a multi-faith centre, which patients or their families could use for prayers and emotional support. Members of staff from the chaplaincy services visited patients and families on request. A patient told us they were offered a visit from the chaplain when required.
- We observed staff giving emotional support to patients and their families. They gave open and honest answers to questions and provided as much reassurance as possible.
- Nursing staff told us that counselling services were available to patients and their families and were always offered following the death of a patient.
- We witnessed nursing staff providing patients and relatives with emotional support. For example, we saw a nurse took time to ensure that a patient who was being admitted had the opportunity to inform their family about their admission.

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

(for example, to feedback?)

Requires improvement

Patients did not always receive timely care and treatment. The emergency department was consistently failing to meet the national standard that required 95% of patients to be discharged, admitted or transferred within four hours of arrival.

The paediatric ED did not always meet the needs of children, due to staffing shortages of registered children nurses.

Complaints were taken seriously. The team learned from complaints received and reviewed ways to improve both their practice and patient experience within the department.

The department was able to demonstrate that despite the increasing demands and attendances, they coped with their routine workload. There was a slow response to assist a consultant undertaking initial assessments once the department became busy.

Service planning and delivery to meet the needs of local people

- The department had limited space that restricted growth, and there was a growing population for the services that were delivered by the department.
- The adult's ED had a ten bedded co-located CDU where patients could be admitted for a short term stay to avoid them been transferred to a ward. The unit was managed and staffed by the ED team.
- The children's ED had opened a two-bedded children's day unit where children could be admitted under the care of the paediatric team during the day time. This

enabled continuity of care for patients requiring short term treatment and observation moving from the ED care to ward based care based in ED. It also avoided them being transferred to a ward, only then to be discharged after all the admission process had been initiated and completed.

- Children's needs were met by the provision of age-appropriate toys and activities, a separate waiting area and different pain-scoring tools.
- The department had a notice board, which displayed information about uniform colours to enable patients to understand the roles of staff according to the colour of their uniform.
- The staff told us the department had an escalation plan which described how it prepared in advance to deal with a range of foreseen and unforeseen circumstances where there was an unusually high demand for services. However during our inspection we observed staff who were undertaking initial assessment of patients coming under pressure due to a busy part of the day. It took some time before extra staff were drafted in to help relieve that pressure.
- There was a waiting room for patients who brought themselves to the ED. The room was shared with the urgent care centre. It had sufficient numbers of seats, a supply of drinks and snacks from a vending machine and a television screen.
- Patient pathways were put into action as soon the patient entered the departments. These meant patients were seen and treated by appropriate staff, that diagnostic tests were carried out, and results were reviewed promptly.

Meeting people's individual needs

- We saw that the department had champions who led on specific areas to facilitate individual needs, such as learning disabilities and dementia care. Staff we spoke with were aware of the needs of patients with learning difficulties and had a good knowledge about how to support people living with dementia. Patients with complex needs were flagged up and assessed as appropriate. Chaperones were available if required.
- Staff had access to translation services by way of a telephone interpreter system. They told us that the system worked well whenever they were required to use it.
- We saw patient information and advice leaflets however; they were all in English and not in any other language or format.
- The department had a room to accommodate a patient presenting with mental ill health.

Access and flow

- The hospital had an escalation policy that described the steps it would take when demand exceeded capacity. Staff were familiar with this policy and were clear about the importance of the hospital and the London Ambulance Service working together as a team to address this issue.
- We spoke with the matron who was in charge of patient flow at the department on the first day of our inspection. It was clear that the matron had a good understanding of the process and the status of every patient.
- The percentage of patients seen within 4 hours was better than the England average before the merger and has since fallen to worse than the England 95% hospital standard target. It fell sharply in December 2014 to 81% and had since recovered to 90% or above from April 2015 onwards.
- The percentage of patients waiting between four and 12 hours before being admitted was better than the England average before the merger in October 2014. Since the merger, the trust was consistently worse than the England average. Averages of 25% of patients were waiting to be admitted in this timeframe between January 2014 – July 2015. The England average in this timeframe was 10%.
- On the first day of our inspection, we found the department was not busy with just about six patients in the department. Although most of the patients had been in the department for less than four hours, one patient had been in the department for over 12 hours. There were a number of reasons that led to the patient breaching the four hour target including waiting for the Psychiatric Liaison team, and the matron was aware and gave us an assurance about the breach.
- We went again when the department became busier. There was one consultant with an inexperienced nurse carrying out initial assessments rapidly becoming overwhelmed by the number of patients coming in on

ambulance trolleys. It took some time before additional assistance from within ED was given. We were not assured that this situation would not happen again once we stopped observing.

- We observed London Ambulance staff waiting with their patients until the ED staff were able to book them in. At one point there were up to four patients on trolleys waiting. Discussions with staff indicated that in busy periods patients and ambulance crew waited in the corridor leading to the ED. We received only trust wide information on black breaches (where handovers from ambulance arrival and the patient being transferred to ED took longer than 60 minutes). These were reported as varying from a high of 242 in December 2014 to a low in June 2015 and starting to rise again as the year progressed to 91 in August 2015.
- The national average for percentage of patients who had left ED before being seen was 2% - 3%. The average for the Ealing ED department between from January 2013 – March 2015 ranged between 2% - 3.5%. This is the Department of Health (DoH) indicator, which potentially showed patients were dissatisfied with the length of time they waited to be seen at the department.

Learning from complaints and concerns

- The Patient Advice and Liaison Service (PALS) was available throughout the hospital. Information was available for patients on how to make complaint and how to access the Patient Advice and Liaison Service. Information about PALS was displayed in the department for patients and their representatives.
- Staff understood the process for receiving and handling complaints and told us information about complaints was discussed during routine team meetings to raise staff awareness and aid future learning. We were told that the overall complaint response rate at the hospital was 85%, most of the complaints regarding ED was about waiting times, communication, and discharge process. We were provided with documents detailing the actions taken to address complaints and concerns, this including meeting the complainant, talking to staff and discussing complaints at team meetings.
- The Matron was able to describe the complaints they had received in the last year and gave details of the complaints investigated and how the patients were kept informed of the progress through meetings and letters to the complainants. Learning from complaints was disseminated to the whole team in order to improve patient experience within the department.

Are urgent and emergency services well-led?

Requires improvement

The ED had governance arrangements that included monitoring risks and quality of service provision. There was an appropriate escalation process for risk, however local leadership (medical and nursing leadership) had expressed a sense of isolation from the rest of the trust.

The vision and strategy of the department was not made clear to the local leadership by the corporate management of the trust. Most of the staff said clinical leadership was good. However we found that action plans were not developed or implemented in response to any deteriorating performance and CEM audits in the department.

Staff told us that the ED had an open and honest culture and excellent teamwork. Medical and nursing leadership were constantly visible in the clinical environment. The leadership team demonstrated the skills, knowledge and experience needed for their roles.

Vision and strategy for this service

- The future vision of the trust was not embedded within the department or the team and most of the staff we spoke with were not able to articulate the vision and strategy of the trust. Senior staff said there was little strategic and leadership direction from the corporate team, even though they had their own ideas on the vision of the ED.
- Staff in the department, were unclear about the future of ED services at the hospital. They were told that the trust intended to close the department in the future. Most of the staff we spoke with were concerned about what the future of ED and the hospital at large, and they were not aware of what the future plans were for the department and the hospital.

- The senior management team were interviewed separately and we noted that their vision was not aligned with one another for the department. Both local and corporate leadership spoke about different priorities and issues concerning the department.
- All the staff that we spoke with said that they enjoyed working in the department and reported being well supported. They were clear about what the department did well and where it could improve.
- The trust had very recently merged with another trust and appointed a new chief executive about 6 months ago. The chief nurse had been in post for a few weeks prior to the inspection.

Governance, risk management and quality measurement

- There were no risk assessments associated with the availability of only one monitored bed and the lack of kitchen to provide patients with hot meals at the department.
- Governance meetings were held within the department and all staff were encouraged to attend, including junior members of staff, lead nurse and governance committee members. Complaints, incidents, and quality improvement projects were discussed. We reviewed minutes from the meeting on 13 July 2015, which showed a comprehensive review of new incidents, the risk register, audits, monthly mortality report, safeguarding, complaints, training and on-going issues. The clinical governance committee reported to the trust quality committee.
- The department maintained a system of quality indicators for monitoring targets; for example, national performance targets, patient safety and quality, NHS Safety Thermometer, patient experience and workforce and safer staffing. These were accessible by all staff for reference.
- Regular liaison between the two ED's (Northwick Park and Ealing) was not evident. At the time of our inspection, it was ad-hoc and informal. We were informed that such liaison would be useful in imparting lessons learned from incidents and communicating good practice across the two departments.

Leadership and culture within the service

- Feedback from junior doctors and junior staff nurses working in the department was very positive. They commented that they had been made to feel part of the team and senior staff ensured they were able to be involved in all aspects of patient care and treatment.
- Nursing staff told us the new senior management team were not visible. Most of the staff we spoke with had not seen any of the new trust leadership in the department, and they did not know them. However, most of the staff spoke very positively about the matron, her senior nurses and how supportive they were, and said they could go to them with issues.
- At the time of the inspection, there was a lack of joint ownership of the issues faced by the department across the trust, because the local leadership and the overall trust leadership vision of the department were not aligned with each other.
- Staff were encouraged and supported to report any issues in relation to patient care or any adverse incidents that occurred. We observed staff from all specialities worked well together and had mutual respect for each other's contribution to the holistic care of their patients.

Staff and public engagement

- The matron informed us that staff were told to actively engage with patients and encourage them to complete the Friends and Family test. This resulted in a mixed response rate for the department. For example in August 2015, the department response rate was only 18% against the trust response target of 40%.
- Most of the clinical and non-clinical staff we spoke with were not aware of any public engagement initiatives by the department whereby input from patients was sought to help improve the overall ED experience.
- There was no evidence displayed in the department of changes made as a result of patient feedback such as waiting times, Friends and Family tests or patient-led assessments of the care environment (PLACE).

Innovation, improvement and sustainability

- There was evidence of innovation in relation to learning and development. For example the department had introduced a Schwartz Round Centre on a monthly basis. A Schwartz Round is a multidisciplinary forum where clinical and non-clinical staff meet to discuss

emotional and social dilemmas that arise in caring for patients. The purpose of the round is not to solve problems, but to explore the human aspects of delivering care that staff face from day to day.

Medical care (including older people's care)

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

Information about the service

Inpatient medical services at Ealing Hospital (EH) compromised of wards 4 South (Cardiology), 5 North and South (Care of the Elderly), 6 North (Gastroenterology and endocrinology), 6 South (Respiratory), 8 South (Infectious Diseases), and the Acute Medical Unit (AMU).

There were 10,400 medical admissions at Ealing hospital in 2014/2015, including 53% emergency, 2% elective, 45% day case. Of these 66% were general medicine, 13% clinical haematology, 9% cardiology, and 12% in other specialities.

We visited all the wards that were open over the course of a one day announced visit and another evening which was unannounced. We spoke with 34 members of staff including nurses, doctors, allied health professionals such as pharmacists, ancillary and administrative staff. This included department and divisional management. We spoke with five patients, checked 14 pieces of equipment and 31 patient records. We also observed care and reviewed other hospital records including policies, procedures, meeting minutes and audits.

Summary of findings

Medical services required improvement at EH in safety, effectiveness, responsiveness and leadership. We were particularly concerned about the sustainability of already stretched staffing levels when a new ward will be opened at Northwick Park which some recently appointed staff will be allocated to.

Patient records were not complete or patient focused in a number of instances.

There was some over reliance on junior staff and there was a lack of cross site governance and working.

Discharges were constantly delayed and patients were not always cared for on the correct ward. There was a lack of support and communication from divisional level.

However we found caring was good overall with positive patient feedback and improving friends and family test scores.

Incidents were mostly learnt from although only if they occurred locally.

There was awareness of the Mental Capacity Act and pain relief was well managed. There was good patient flow through the AMU and complaints were learnt from.

There was support from local leadership and some performance oversight.

Medical care (including older people's care)

Are medical care services safe?

Requires improvement

Safety on medical wards at EH required improvement. There was a lack of both permanent medical and nursing staff and although this was improving, we were concerned a high number of recently recruited staff would soon move to the new AMU at Northwick Park which would then increase the vacancy rate again. Most patient records we reviewed were either incomplete or not fit to meet the patient's needs. Investigations into serious incidents did not follow best practice. There were some concerns with cleanliness and the state of repair or servicing of equipment and fixtures.

However mandatory training rates were improving. Deteriorating patients were identified and escalated as needed. Incidents were reported and learnt from at a local level. Patient harms were around the national average other than a high rate of falls in some areas. Medicines were mostly well managed and stored securely.

Incidents

- There were 17 serious incidents declared by medical services at EH but none in recent months. Three were grade four pressure ulcers (PUs), three were grade threes PUs, two were falls, and there was one each of various others including ambulance delays, medicine errors, and safeguarding incidents.
- There were a total of 9402 incidents reported in the trust wide medical services in last 12 months. These were mostly PUs, admission delays, falls, and administration of medicines incidents.
- Staff were aware of how to report an incident and received individual feedback. Although agency staff could not report incidents themselves as they did not have access to the system, they knew who to report them to. Staff were able to give examples of incidents that had occurred and were able to describe actions that were taken to stop further incidents in the future such as checklists for allergies. A lesson of the week meeting was undertaken every Friday in the AMU where staff could present an item of learning from an incident they had been involved in.
- However, we did find a few members of staff were unclear what constituted a serious incident. One example was not declaring a grade three pressure ulcer as a serious incident, which is contrary risk rating criteria. Staff also reported not getting learning from incidents from across the other trust locations.
- We reviewed five root cause analyses of serious incidents, which included one, we could identify as occurring at EH. The investigation did not follow a proper root cause analysis process with only an incident background, medical history of the patient and chronology. There were no contributory factors, root cause or recommendations stated.
- Staff were aware of their responsibilities under Duty of Candour including the need to apologise after an incident and the need to share the investigation with the person affected. There was a trigger on Datix for duty of candour when an incident was moderate or above. Training for duty of candour was part of risk management training. Duty of Candour is a regulation under the Health and Social Care Act which aims to ensure that providers are open and transparent with people who use services and their carers. It sets out some specific requirements that providers must follow when things go wrong with care and treatment including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.
- We requested mortality and morbidity meeting (M&M) minutes but the latest we received were for April 2015 and only focused on infectious diseases although previous minutes had other specialities. None of the staff we spoke with told us M&M meetings took place. Clinical governance meetings acknowledged that M&Ms only occurred ad-hoc across the division.

Safety thermometer

- Safety thermometer results were displayed in all the ward areas we visited, including staffing levels, pressure ulcers, urinary tract infections, and falls. Across the trust, pressure ulcers, UTIs, and falls were around the national average. Audits for care bundles relating to patient harms were mostly 100% or just below 100% and we found very few of these care bundles were not completed.
- Falls were a particular concern on the care of the elderly wards, particularly 5 North ward where there had been over 30 in 2015/16 compared to nearly 20 on 5 South

ward. Although no patients had suffered a fracture, we asked why there had been a high level of falls on 5 North ward. Senior staff were not able to tell us although they acknowledged there were less health care assistants on this ward compared to 5 South despite being staffed to patient acuity and dependency.

- In more recent months, 6 North ward had a higher amount of falls than the care of the elderly wards. Senior nursing staff acknowledged this but they said this was due to the patient group as many had alcohol related impairments although we observed patients were well supervised. A falls committee did take place but was always based at another trust site.

Cleanliness, infection control and hygiene

- There had been some acquired Clostridium Difficile but they were in different wards and there was no identifiable trend. However although Methilicin resistant staphylocous aureus audits showed mostly 100% or near compliance, we found most patient notes showed swabs had been taken but no result had been recorded.
- We observed all the medical wards to be clean and tidy including sluice areas. It was particularly impressive on 6 North ward where sluices and commodes were cleaned at least three times a day. This was recorded on the equipment. Patients we spoke with also said the hospital was mostly clean.
- The utility room for the AMU was not separated between "clean" and "dirty" areas due to its size and we found a dirty shower seat in the AMU. This was cleaned once we brought it to the staff's attention. We requested cleanliness audits but did not receive any for EH other than the AMU. This scored 90% but had issues with walls, TV, floor, high surfaces, alcohol dispensers and curtains and some areas were not scored.
- There were no sinks in the rooms on the infectious diseases ward; staff had to wash their hands outside in the main ward corridor before entering. In addition, none of the rooms had negative or positive pressure to control the airflow going into or out of the rooms despite requiring at least two. This arrangement was not appropriate particularly for an infectious diseases ward.
- Although there were appropriate bins in all areas, their use was not always appropriate with medicine bins used for sharps.
- Senior staff told us the infection control team needed to train and support the ward staff more in areas such as confidence in challenging doctors who do not adhere to guidance. Audits showed hand hygiene was a concern with some wards either not submitting audits or scoring less than 90%. However, we found staff mostly observed appropriate infection prevention and control guidelines such as wearing personal protective equipment and washing hands between patient interactions.
- Staff observed bare below the elbow practice in all clinical areas that we inspected.

Environment and equipment

- Most of the equipment we checked was clean. Those that were had stickers to show they had been cleaned in the last 24 hours. In addition, servicing of equipment was up to date.
- We found a sink that was in a state of disrepair, toilet seats that were cracked or unclean and shower curtains that were in poor condition. However, when we pointed out the areas that required cleaning, staff attended to them immediately.
- Resuscitation trolley checks were not always up to date and some were only conducted weekly.
- Temperatures in the bathrooms were significantly colder than the rest of the ward.
- Some staff told us equipment that required repair or replacement could take some time unless it was urgent. Staff told us some items that had required maintenance for months and had only been repaired in recent weeks.

Medicines

- Patients that needed oxygen had oxygen prescribed appropriately although there were a few errors and sometimes where limited oxygen was prescribed unlimited oxygen was given (for example as the driving gas for a nebuliser).
- The fridge in one of the wards did not show a stable temperature with different recordings between the thermometer on the inside and the displayed temperature on the outside with one of these over the required temperature to keep medicines cold. There were also no recorded actions to show what was to be done and staff were also not clear on what action was required. However, later in our inspection, the trust installed a new fridge.
- Intravenous fluids were appropriately stored and locked. Patients own medicines were locked away appropriately and not used during their admission but given back on discharge. However, staff we spoke with were unaware if there was a self-administering policy.

- Staff told us to take away medicines (TTAs) were kept in cupboards locally on the ward. However, we did not find this was the case when we checked the cupboards ourselves.
- The use of summary care records (SCR) had been implemented at Ealing hospital to assist with the completion of medicines reconciliation, which both pharmacists and pharmacy technicians were trained to carry out. The medicines management technicians were also trained in medicines reconciliation and they were accredited via London Pharmacy Education and Training.
- There was evidence of good antibiotics stewardship. The antibiotics section of the Ealing hospital drug chart had been designed in such a way that it ensured that a doctor reviewed the need for the antibiotic after three days, and again after seven days. The indication for the antibiotic was required on the drug chart, as well as the name of the staff member from the microbiology team that was involved in the decision to prescribe the antibiotic. Gentamicin and vancomycin both had their own drug charts, which prompted the clinicians to take the relevant drug monitoring levels before the medicine was continued. Point prevalence studies (an assessment of the use of antibiotics and level of compliance with the antibiotics guidelines) were conducted every six months, and the outcome data was then fed back to the antibiotics stewardship group and the Drugs and Therapeutics Committee.

Records

- Most patient notes we checked had illegible signatures and medical staff did not always use stamps or print their names to show who had reviewed the patient. The medicines safety team had undertaken a recent audit on this and results were due shortly. However a records audit in 2015 reviewing 50 notes across seven specialities stated most notes were fully complete with dates and signatures with all at least 75% fully correct, which was much better than our findings.
- Care plans were not personalised to individual patients. Falls, diabetes and hygiene plans to mitigate risks were all pre-populated and therefore were at risk of not meeting patients' individual needs. They did not always describe why there was a risk or the actions did not correlate to all the risks described.
- Some aspects of patient records were incomplete. For example one set of records had a patient's weight recorded but not on the weight chart. Fluid balances charts were not totalled, MRSA swab results not recorded, and dementia questions not answered. Another had no score for the waterlow skin assessment, no record of the fluid output, and no result on the MRSA swab. Some of the nursing assessments were not dated. We found two sets of notes where a night entry had been completed for a patient regarding their sleep at the start of the night shift and multiple others where times of review had not been recorded. When we spoke with staff about the quality of patient records, they agreed there was a lack of personalisation and were incomplete in places.
- An electronic record system (EPIC) was in place on the AMU and care of the elderly wards, which was user friendly. It showed when patients were within 48 hours of expected discharge, if they were medically fit; if there were any conditions or support arrangements that staff needed to be aware of such as allergies or learning disabilities as well as if a patient was due for a doctor review due to a high national early warning system score.

Safeguarding

- Staff were aware of their responsibilities to safeguard vulnerable adults and knew whom to report any concerns to.
- We saw examples of safeguarding referrals which were mostly when a pressure ulcer had either deteriorated or been acquired. However not all acquired pressure ulcers had been referred for safeguarding.
- We received the mandatory training results for safeguarding both adults and children at level one to three for July 2015 and these were split by both speciality and staff group. They showed variability in completion with a number of areas at 100% in all their safeguarding training but others at around 50% or lower including cardiology (administrative, health scientists and medical staff), gastroenterology (medical), general medicine (medical and nurses), acute medicine (medical), care of the elderly (medical and additional clinical staff).

Mandatory training

- Staff told us they were up to date with their mandatory training and figures showed training rates had been improving to around or over 80% overall after some wards were below 70%.

- Staff said their line managers prompted them when a course was due for renewal. However, staff still were concerned that they had to complete training in small modules on the new 'ELMS' system rather than all in one or two days as they used to. They said this had a negative impact both on the training rates and the ability for staff to take time out to train. Some staff told us they had completed training outside of work time to get up to date.

Assessing and responding to patient risk

- All the national early warning scores (NEWS) were checked. They recorded that patients were observed and escalated appropriately if they deteriorated. Interventions by medical staff or the critical care outreach service (CCOT) were timely when a patient was escalated to them. Audits showed NEWS were being recorded and patients escalated appropriately.

Nursing staffing

- The trust stated they set staffing levels to a minimum nurse to patient ratio of 1:8. Although there were still high vacancy rates on medical wards (around 20% from 40% a few months before), we found staffing levels were either at or better than the acuity and dependency of the patients on most wards and these were maintained. One ward had deliberately increased its establishment of health care assistants. This was to ensure it did not have to constantly request additional ones for patients that required one to one care as they were required so often. This meant five registered nurses and six health care assistants covered 30 patients. Other than the nurse/patient ratio referred to above we did not see evidence of a recognised acuity tool being used to determine specific nurse staffing levels.
- We were concerned vacancy rates would go back up as some of the staff were due to move to the new AMU at Northwick Park once it opened.
- Staffing at night was more stretched. There were a higher amount of agency staff at night and although they had an induction checklist, we were concerned this diluted the skill mix as agency nurses were not always trained in the ward speciality such as non-invasive ventilation (NIV), heart failure or diabetes. On AMU, 60% of the staff at night were agency. Otherwise agency use we observed and recorded was around 30%.
- The staff ratio for the acuity and dependency on the respiratory ward was not always appropriate as they cared for patients with tracheostomies and non-invasive ventilation and staffing was not always increased to meet the numbers of these patients. This meant the establishment did not comply with the recommendations of the British Thoracic Society/Royal College of Physicians of London and Intensive Care Society for nurse patient ratios for those receiving NIV or having tracheostomies. Eight nurses covered six patients each though non-invasive ventilation (NIV) patients were supposed to have one nurse per two/three patients. We were told if there were over five NIV patients admitted, some would go to the cardiac ward as there were NIV trained nurses there. The coronary care unit (CCU) had three nurses covering up to four patients each whereas the cardiac ward had three nurses and two HCAs covering up to 24 patients which dropped by one HCA at night. The care of the elderly wards were not meeting the skill mix required for the patients they cared for due to the lack of nursing retention with nurses moving to other departments in the hospital. This meant there was a lack of band 6 nurses and over reliance on overseas nurses, although they were on conversion courses.
- Some HCAs told us they were overstretched. On one ward, two HCAs covered 12 patients each. There were also concerns that there was a higher use of agency at night.
- Agency staff used were mostly regular to the hospital. Staff confirmed there had been high amounts of agency staff but this had recently decreased which had improved the quality of care. However concerns were raised by staff regarding the process to approve agency and additional staff. Approvals were required by the divisional team rather than by the department or matrons. This meant the process could be lengthy and at risk of not being approved in time. The process had been changed in recent months by the executive team to reduce the amount of staff spending at the trust. This was particularly difficult for Ealing as they had less bank staff to use.
- Ward managers were supernumerary and rarely had clinical duties. However, although there were clinical educators in the hospital, there were no practice development nurses (PDNs) dedicated to the wards which is contrary to Sir Robert Francis' recommendations although they were trying to recruit. The last PDN had recently left.

Medical care (including older people's care)

- Handovers were not always appropriate as sometimes agency staff were handing over to each other with no permanent staff involvement. In addition, handovers we observed had no staff huddle, only a nurse to nurse bedside handover which meant staff were not aware of any patients in another bay. Also the bedside handover focused on the nursing side of care such as assessments and not treatment plans or social history. However, there was a handover checklist that was completed and both staff had to sign to ensure handover had occurred although completion of the forms varied from ticking the relevant assessments to dating when they had been completed.
- Senior staff acknowledged there was difficulty in recruiting staff due to the perception of services closing at Ealing, particularly for the respiratory ward. However recruitment drives were ongoing including weekend recruitment days and right registered nurses had been recently appointed from overseas.
- To increase retention, overseas nurses were buddied up together and had a competency programme such as supernumerary working, and social events with a non-overseas nurse overseeing them. Encouragement was also given to student nurses to take up their qualified posts at the hospital. Rotation was also being looked at.
- Some staff were permanently rostered to conduct night shifts and/or weekends and this had led to concerns about their training and development.
- We saw no evidence of comprehensive recruitment and retention plans beyond the use of bank and agency staff and ad hoc measures described above to fill vacancies. We did not see displays on the wards of planned versus actual staffing. We did not see a red flag system when staffing levels fell below a certain level.

Medical staffing

- We were satisfied with the amount of junior medical staff on shift. Care of the elderly wards had a registrar, senior house officer (CT1) and three house officers (FY1 and 2s) which staff said was sufficient. The haematology ward had two junior doctors (an SHO and a registrar) on shift each day. The diabetes and gastroenterology ward had three consultants, two registrars (one was locum), two clinical fellows, two CT1s and three FY1s. Consultants on this ward were on shift for two weeks before a rotation.
- There was a lack of permanent consultants with two locums and one permanent consultant covering the care of the elderly wards and two out of three of the respiratory consultants were also locums. It is not clear whether this was on the Trusts risk register but as a result of this and other factors, trainee respiratory/ general medical registrars had been removed from Ealing Hospital further compounding the problem. This had an effect on care of the elderly wards as they said they did not have enough time to participate in national audits so they were unable to tell us about patient outcome performance. Recruitment for a geriatric consultant had been ongoing but unsuccessful. Senior staff acknowledged recruitment and retention was difficult due to the perception of services closing at Ealing so they were looking at recruiting consultants to work cross site. However some staff were worried that this was unlikely to succeed.
- At night, first year junior doctors (FY1s) covered medical wards unsupervised. There was a medical registrar on site and consultants were on-call but juniors told us the senior doctors were often in A&E clerking patients. They perceived a lack of support from some of the on-site team as a result.
- There were no plans to recruit physician associates or acute care practitioners although senior staff acknowledged it may be an area to look at in the future.
- Ward rounds across the services were daily led by the consultant on shift that day with a grand round once a week for clinical teaching.
- Patients who were outliers were cared for in different ways. On some wards, the host speciality would take on their care after an initial review by the speciality pertinent to the patient's condition. For other patients, there was dual care, with reviews by both the pertinent and host specialities, mostly when a patient had multiple co-morbidities in different specialities.
- There was one registrar on-call for the gastrointestinal bleed rota each day with a second on-call on the wards at weekends with each registrar conducting around one shift a week and one in six weekends. However we found patients were being transferred to Northwick Park for endoscopy.

Major incident awareness and training

- There was some awareness of major incident plans. Staff were aware of what a major incident was and knew they had to respond but were sometimes unclear on

what the procedure would be. For instance, there was limited awareness on the criteria for discharging patients in the event of a local major trauma incident such as a motorway pile up or airline crash.

Are medical care services effective?

Requires improvement

The effectiveness of medical services required improvement. There was a lack of nutritional and fluid monitoring. There was local auditing which was showing improvements in a number of areas but a number of audits had not been completed for over two years. There was a lack of multi-disciplinary working cross site.

However national guidance was mostly followed, pain relief was well managed, appraisal rates were improving and there was an understanding of the Mental Capacity Act and Deprivation of Liberty Safeguards

Evidence-based care and treatment

- We found evidence to show that the wards were complying with national guidance such as National Institute for Health and Care Excellence (NICE) including local policies and procedures and updates in department meetings. Some staff were using applications on their mobile phones to look up national guidance.
- Early warning score audits were in line with national guidance.
- Daily checklists were supposed to be completed by the nurse in charge regarding displays on performance, signage, equipment, call bells and cleanliness. However the checklists we reviewed had multiple days where no checks had been conducted.
- An alcohol withdrawal audit was undertaken in 2015 reviewing the clinical institute withdrawal assessment (CIWA). This showed a big improvement on use of the CIWA since 2013 from 8% use of the tool to 73%.
- An audit on the use of high dose statins after an acute myocardial infarction (heart attack) took place in 2015. It found only 64% of patients were given the correct dose of statins on discharge out of 25 patients and no reason for the incorrect dose was given. Recommendations were made including checklists at discharge.
- An audit was conducted on use of reusable tourniquets for venepunctures (taking blood samples) by junior doctors as use of these is contrary to infection control guidance. This found a high proportion of junior doctors both when audited initially and re-audited, were using either reusable tourniquets or gloves rather than disposable tourniquets.
- We received a number of other NICE audits that had been conducted but they were in 2013 or 2014 despite our request that they be within the last 12 months. We were therefore unable to review the most recent performance.

Pain relief

- Patients told us their pain was controlled and records showed pain scoring was undertaken and appropriate pain relief given when appropriate.
- Staff were complimentary about the pain team although most of their interventions were for surgical patients.

Nutrition and hydration

- We had concerns about the management of patient nutrition and hydration:
- We observed and patients also told us that they always had something to drink that was within their reach.
- Most patients were happy with the choice of food including roast dinners on a Sunday.
- However, Malnutrition universal scoring tool (MUST) assessments were either not completed or not completed appropriately in many instances. In addition, fluid balance charts were also either not completed or not completed appropriately. For example, some patients had high body mass indexes but these were not flagged as a risk despite scoring on the MUST. Fluid balances were not totalled. Audits for nutrition were variable with most wards scoring over 90% but 6 South ward scored 73% compliance.
- Staff were complimentary about dieticians but they were only available on a referral basis.
- Food standards were mostly RAG rated by the hospital as amber other than menu planning, and MUST which were rated by the hospital as Green.This did not correspond with our observations.
- We did not observe nursing staff actively assessing or promoting oral hygiene and mouth health in their patients. We did not see any trust guidelines or policies on patients' oral hygiene.

Medical care (including older people's care)

Patient outcomes

- There was a lack of national auditing on patient outcomes in some areas. The care of the elderly wards did not participate in fragility audits and claimed that a lack of permanent consultants prevented them from doing so. Staff were unaware of any national or local audits specific to infectious diseases or haematology.
- EH had a better than average performance in the Myocardial Ischaemia National Audit Project (MINAP), particularly for admission to the cardiac unit.
- EH had a worse than average performance in the national diabetes audit (NADIA) in 14 of 21 indicators including medicine errors, prescription errors, management errors, insulin errors, foot risk assessment in 24hrs, foot risk assessment during stay, meals, self management of diabetes care, staff awareness of diabetes care, and staff knowledge on diabetes. Staff told us there had been specific teaching in relation to this audit such as safe prescribing of insulin. A new NADIA audit had recently been completed and staff believed they had improved their outcomes this year although the report had not yet been published. Other diabetes related audits that had been undertaken including acute kidney injury and foot examination although staff were not aware of the results of these either.
- Average length of stay (ALOS) was lower than the national average for elective patients but higher for non-elective, particularly in care of the elderly wards. We found discharges were often delayed which was contributing to this.
- Patient satisfaction data was collected using a tablet at Ealing hospital pharmacy outpatients and this data helped to inform interventions to improve the patient experience. For example, patients expressed that they wanted more confidentiality when speaking to staff at the pharmacy hatch. As a result, two glass panels were installed either side of the pharmacy hatch to increase patient confidentiality.
- The hospital was not an outlier for mortality on data which CQC held, but the division had no mortality statistics on its monthly performance dashboard.

Competent staff

- Agency staff were appropriately inducted with checklists and orientations completed before they started a shift. Those that did not have the particular competencies for the ward took on the less acute patients such as no NIV. However the trust induction for new permanent staff was not always appropriate with a lack of a comprehensive corporate and local induction which sometimes comprised of very few days before starting shifts and being counted in the shift numbers.
- Appraisal rates as of July 2015 in medicine varied from above 80% to below 50% in some wards with a trust target of 95%. We received varied feedback regarding appraisals with some staff happy with their appraisal which they received regularly whereas others said they either rarely had them or not at all. Appraisal rates reviewed showed some wards had completed their appraisals in summer 2014 which meant their overall rate was low as they were trying to catch up, whereas others had better maintained their appraisal rates as they had been staggered throughout the year. Specialist medicine staff told us their appraisal rate across the trust was 71% but could not give us information site specific.
- There were no practice development nurses but there were clinical educators although they were not dedicated to individual wards or areas.
- Nurses were able to undertake mentorship courses but there was variable feedback from nurses on whether they received patient specific training such as dementia or diabetes. On the respiratory ward, all but two permanent nurses were NIV trained and band six nurses were critical care trained with plans for band five nurses to be trained as well. There were tuberculosis (TB) specific nurses on the infectious diseases ward who undertook HIV and TB courses. Clinical nurse specialists were available for patients with diabetes. Shift and patient allocations were made depending on the training staff received.
- Junior doctors gave mostly positive feedback about their support including regular training, appraisals and variation of work. They told us there was an opportunity to shadow before being on shift and they received good documentary advice and support. However we were concerned about the responsibilities they were being asked to undertake when there was either a lack of on-site supervision or the frequency of their rotas. Junior doctors said on-call was onerous. They said that site team support was variable and that there appeared

to be a lack of transparency as to the amount of nights juniors undertook. Some of the patients we spoke with at our listening event said that trainee doctors were not always carrying out procedures correctly.

Multidisciplinary working

- There was a lack of multi-disciplinary (MDT) working cross site. Tissue viability services worked cross site and some of cardiology and respiratory services. There was also some systems working multisite such as the picture archiving and communication system (PACS). However, staff we spoke with in the pharmacy departments had not met and did not know their counterparts at the other sites. This was contrary to information we received at a focus group. Other staff said and meeting minutes showed there was very little cross site working in the different specialities.
- Although there were meetings with community services, senior staff said the services were not joined up. There were plans to rotate staff between community and acute for heart failure and diabetes as well as integrating pathways.
- All patients on AMU were discussed across all specialities every morning regarding their last 24 hours and reviewed on a ward round and bed meeting in the afternoon. Nursing staff described a good relationship with doctors and therapists including at night.
- MDT meetings occurred on the care of the elderly wards daily and for tuberculosis patients once a month which included case reviews but also other areas such as drug errors and new NICE guidance.
- All types of therapy visits were unscheduled so we were concerned patients could miss their therapy if they were away from their bed or in pain.
- There were links with Harefield Hospital for long term NIV patients.
- An MDT records book was kept on wards but this only documented a brief summary of an intervention for a patient such as 'wean from 02' and 'community rehab referral'. It was not clear how useful this would be as a communication form between different staff groups other than as an aid memoir for them to look in the patient notes.

Seven-day services

- Pharmacy was open Monday to Friday, 9am to 6pm. Pharmacists undertook bespoke ward rounds. On AMU there was a band seven pharmacist with a pharmacy technician or part time pharmacist on week days plus a supernumerary pre-registration pharmacist.
- There was seven day working for all types of therapists and pharmacists including on the wards with a pharmacist between 9am and 1pm at the weekend.
- There was an on-call pharmacist available on all sites who could be contacted out of hours for assistance with medicines supply issues. However they were not commissioned to dispense discharge medicines out of hours for patients wanting to go home. There was also a medicines helpline available for patients discharged from the trust.
- The respiratory ward had a dedicated physiotherapist who also was responsible for the ITU and they were on-call at weekends. Care of the elderly wards had dedicated physiotherapists and occupational therapists who were available on-call at the weekend. Imaging was available seven days a week although only urgent scans could be done at weekends and there was no bone density scanning at the hospital.
- Consultants were available on-call out of hours with a medical registrar the most senior clinician on site. However there was seven day working during the day with consultant presence.

Access to information

- The IT system sent an email to the patient's GP when a consultant treated them, with electronic discharge summaries and clinic letters sent.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff were aware of their responsibilities to undertake Deprivation of Liberty Safeguards applications when patients were restrained from leaving the premises against their will and we saw examples where this was in place.
- Staff knew their responsibilities under the Mental Capacity Act including the process for a doctor review of their capacity and best interest assessment if needed. We saw examples of best interest assessments completed and these were appropriate such as use of mittens when patients were pulling out their intravenous lines.

Medical care (including older people's care)

- We saw examples of staff using appropriate de-escalation techniques to calm down agitated patients without having to use restraint.

Are medical care services caring?

Good

Inpatient medical services were caring. Patient feedback was that they were cared for with privacy and dignity. Patients, family and friends said they were involved in their care and emotional support was available.

However, we observed some instances where patients were not involved in their care because staff talked over them.

Compassionate care

- All the patients we spoke with were happy with their care from all staff groups. They told us their privacy and dignity was maintained during personal care and that staff were kind and caring. Nurses answered call bells quickly. Patients were not woken for washes at night unless they were required. However, a few patients told us they had not seen a doctor every day.
- Friends and Family Test (FFT) response rates were above average at 41.8% with some wards getting a 60 to 80% response rate. Eight wards scored between 46 and 100 with most at or above 93% recommending or highly recommending the trust. However the AMU response rate was low at 8% and some ward were not reporting scores in some months.

Understanding and involvement of patients and those close to them

- All the patients, family and friends we spoke with told us they were involved in their care with treatment and options explained to them in ways they could understand or repeated in a different way.
- Some nurses we observed did not have name badges which meant patients may not have been able to identify them. This was confirmed by some patients we spoke with at our listening event. However, patients told us there was some continuity of care of those nurses looking after them each day.
- We observed a few occasions where staff were talking to each other in another non-English language within hearing distance of patients where it was not the patients' own language.
- Medicine rounds took place at 6am. This meant some patients had to be woken to ensure medicines were taken.
- Handovers we observed did not involve the patient. Staff talked between each other at the patient's bedside and only friends and family got involved when staff wanted clarification. There was no explanation to the patient or family about what the handover was or what they were discussing despite the patient's being conscious.

Emotional support

- Psychiatric support was available for patients and their family if they wanted it. Nurses told us psychiatric support was available on referral and they were responsive including at weekends. This included MDT meetings with those involved in the patient's care.

Are medical care services responsive?

Requires improvement

The responsiveness of inpatient medical services required improvement. There were constantly delayed discharges which was leading to patients acquiring other conditions and arrangements to support discharge were not adequate. There was a lack of accommodation arrangements for families to stay overnight. The hospital did not meet the environmental requirements for those that were immunosuppressed or infectious. Medical patients were often cared for on the incorrect speciality ward. There was a lack of support for patients living with dementia.

However flow on admission was well managed from the AMU to the speciality ward. Referral to treatment targets were mostly met. Complaints were learnt from although there was a lack of physical evidence this was the case.

Service planning and delivery to meet the needs of local people

Medical care (including older people's care)

- Visitor hours were normally restricted but we saw examples of where this was relaxed depending on the circumstances.
- There was no accommodation on site for visitors or any local arrangements with hotels or other accommodation providers. Those that required to stay over were made as comfortable as possible on chairs in the patient's room but the chairs were not designed to sleep in.
- Due to the lack of side rooms at the hospital, there was pressure on the infectious diseases ward to take patients who required a side room such as those at the end of their life or those who were infectious. However this sometimes meant patients that should be admitted for that ward sometimes had to be admitted elsewhere and moved later on.
- There was a lack of entertainment facilities such as televisions on the wards.
- The latest Patient Led Assessments of the Care Environment found Ealing Hospital was below the national average for every indicator and particularly for privacy and dignity.

Access and flow

- Medical services were meeting the admitted referral to treatment 18 week 90% target in all specialities other than cardiology and general medicine.
- There were seven declared medical patients that were outliers in June 2015. We found medical patient outliers, being cared for on other wards including cardiac and care of the elderly wards. The trust executive had proposed a process called 'breaking the cycle' which would look at reviewing and recalibrating the services provided including trying to better prevent patients in outlying beds where they were cared for on the wrong ward.
- Medical patients flowed with little delay between A&E or admission, through the AMU to a specialist ward. Very few patients stayed in the AMU more than 48 hours and a high proportion were transferred or discharged within six hours. However some staff seemed to think the target for transfer or discharge was five days.
- There was fast tracking in place for patients who were ill to the relevant specialist wards and patients could be discharged if they only required a follow up appointment with an acute physician. Delays often occurred when discharging from a specialist ward, particularly on the care of the elderly wards.
- There were no ward based discharge coordinators so continuing care assessments and other social services paperwork either had to be completed by the nurses on the ward or the hospital wide discharge coordinators. On one ward we found eight patients that were medically fit and waiting for discharge. Although discharges did occur at the weekend, these were discharges that did not require social services involvement.
- Senior staff acknowledged there was a discharge issue but their opinion was that the issue was mostly a lack of nursing home placements in the community. Plans were in place to train nursing staff on home care assessments so they did not have to rely on the discharge coordinators.
- A discharge lounge was available for patients waiting for transport or medicines before they were discharged and this included bed spaces for those who were not mobile.
- Video conferencing was used for bed meetings which was primarily conducted from Northwick Park but had updates from all the Matrons at Ealing. This included current bed availability by ward, and admissions waiting in A&E.
- Plans were in place for winter pressures although additional beds had not been commissioned to open. Escalation beds were sometimes put in the day room on the cardiac ward if there was a shortage of capacity. The service was also looking to utilise beds in a former maternity ward.
- Bed occupancy was above 85% on most wards, particularly the care of the elderly wards. Research shows bed occupancy above 85% creates a higher risk of compromised patient care.
- Staff were concerned about the inflexibility of the schedule of ward phlebotomists. They commented that wards were always covered in the same order no matter what the discharges or requirements of each ward were. This meant some wards were not reached until 1pm and therefore their discharges might not have their blood tests back in time to discharge the patient the same day.
- Nurses working on the acute medical units had access to 'to take away' (TTA) pre-packed medicines that could

be given to patients on discharge when the pharmacy department was closed, however discharges were usually planned so that discharge medicines were not usually required out of hours.

Meeting people's individual needs

- Translation services were available both via booked interpreters and language line. Staff told us they booked interpreters when consent was required but also used either their own staff or the patient's family for day to day communication.
- 5 South ward was described as a 'dementia friendly ward' and we observed some aspects met the individual needs of patients living with dementia such as clear bold colour coding between different areas, picture signage on toilets and a dayroom for activities such as reminiscence and music which had led to a reduction in falls. Some of the signage was replicated in other wards. However, patients living with dementia were not specifically triaged to be admitted to this ward and some aspects of the ward were concerning. This included sofas with no arms plus a risk of sliding forward which meant a risk of a fall. The sofas were also placed facing away and below the nurses station which meant a staff member would have to either accompany them on the sofa or watch them very closely.
- Senior staff at Ealing described having a lack of resource to ensure care for people with dementia would meet the actions in the dementia plan for the trust as they only had one Clinical Nurse Specialist covering 300 beds across all care of the elderly sites plus dementia champions for each ward. They told us they received no budget for meeting the dementia targets.
- Dementia care bundles were in place although some staff were not aware of them and we found the CQUIN assessment was not always conducted in AMU. Overall screening for dementia was 77.8% and assessment was 93.7% against a target of 90% but this was across the trust and not broken down by site.
- There were specific leaflets for the type of ward patients were admitted to. For example, the infectious diseases and haematology ward had ones on blood conditions.
- Those patients with complex needs including dementia or learning disabilities were flagged on each ward's electronic system so staff knew to review the patient's records for their particular support needs.

Learning from complaints and concerns

- We found most complaints were being dealt with informally by staff on the wards but these were rarely recorded. Staff told us complaints were discussed at team meetings including any learning although not all meeting minutes we reviewed confirmed this. We saw very few complaints leaflets with only a couple of wards stocking them in public areas.
- EH had an overall response rate to complaints of 85% within 28 days. However there were very few formal complaints with six in a month for the inpatient wards. We were told most were regarding communication. We requested examples of complaints responses but only received ones relating to sites other than Ealing Hospital. Staff told us actions were implemented following complaints such as the activity room on a care of the elderly ward.
- Wards recorded informal complaints and compliments on paper. One ward had 14 records in 2015 so far which varied from concerns about attitude of staff to wait times and communication. Actions to address the concerns were noted but some just stated 'talked to patient' whereas others were discussed at nurse meetings.

Are medical care services well-led?

Requires improvement

Leadership for the inpatient medical services required improvement. There was a lack of strategic direction for EH and this was leading to uncertainty among staff. Although the governance structure was new, there was a lack of cross site governance at department level and there was a lack of communication and support between some departments and the divisional leadership. There was a lack of awareness or recording of some of the risks in the division such as patient records and discharge.

However, there was some good local governance and teamwork at ward or department level although this was EH specific.

Vision and strategy for this service

- Most of the staff we spoke with were concerned about what the future of Ealing Hospital was going forward

and were unaware of what the plans were in the short term. There was no awareness from staff on the infectious diseases and haematology ward what the vision for the future was other than recruitment.

- The strategy for medicine at the trust had very little focus on Ealing. Senior staff at Ealing said there was no or little strategic direction from the division although they had their own ideas on an Ealing vision such as having a fragility unit or older persons rehabilitation assessment centre (OPRAC), staff rotation between wards, a dementia matron and anti-falls equipment although this was only in drafted written form in a notebook. The 2015/16 strategy for the division focused on harmonisation, a move of gastroenterology for Ealing but we saw little evidence that these had progressed.
- The vision and strategy of the service did reflect some current risks such as nurse and consultant staffing levels and falls plus some reflection on inpatient performance such as length of stay.

Governance, risk management and quality measurement

- The governance structure for medical services included clinical, nursing and managerial leads at division and department level with departments split into care of the elderly, emergency and acute pathways and specialist medicine. However there were no clinical leads at department level in place at the time of our inspection. There were lead consultants for each speciality at each site. Most of the divisional and department posts were new due to the divisional structure only recently being in place. The clinical director was part of the executive team.
- Governance structures were partly in place in most of the Ealing site but they were not joined up with the other acute sites and there was no or little feedback at divisional level back to the departments at Ealing about trust wide issues.
- Performance management was mixed and not uniform. Staff in care of the elderly told us they only monitored performance with emails giving current statistics. We received no minutes of meetings in haematology, infectious diseases or care of the elderly so we were unable to ascertain how robust their reporting and governance structures were. There had been one cross site meeting in diabetes and endocrinology. However this reviewed some current services and training rather than performance or incidents. There were ward specific dashboards that monitored assessment completion, equipment checks and medicines.
- Medicine wide clinical governance meetings took place that purely focused on EH which included incidents, risk registers, audits, national guidance, complaints, and safeguarding. Staff were informed of actions in summary form but with little to show what action was being taken in specific areas such as high falls rates or complaints trends.
- A partial review of clinical governance was held at the recent divisional clinical governance meetings to define terms of reference with some brief performance reviews such as incidents, appraisals, action plans and complaints. However it only had the divisional leadership in attendance with no one at department level which was the case at previous meetings. There had been some divisional monitoring of performance such as patients coming to harm, appraisals, delayed transfers, times of discharge and infection rates.
- We reviewed the medical services division risk register which included areas we identified as concerns such as bed capacity, and staffing but not discharge or record completion. In addition, such risks were over two years old with no date for completion. However, actions were in place to remedy the risks such as additional bed capacity, recruitment and auditing.
- Ward meetings varied. Some minutes we reviewed showed unstructured agendas that dealt with pertinent issues at the time such as recent incidents or audit results, whereas others were structured but repetitive such as uniform and staff breaks policies. The former was more appropriate as there was clear review of performance and feedback on incident learning which the other meetings did not. Attendance was appropriate with both senior and junior nurses in attendance.

Leadership of service

- All the staff we spoke with told us they were happy with the support they received locally from their matrons, consultants, service managers and heads of nursing at a department level and that leads at this level worked together well. However as governance still occurred in a split way between Ealing and the rest of the acute sites, staff did not feel as supported by their divisional management.

- Leadership accountabilities appeared to be unclear. For example, there was a deputy head of nursing and general manager for care of the elderly services with job descriptions that included having oversight of all the trust sites providing care of the elderly wards. However, we were told the deputy head of nursing was not able to have oversight of sites other than Ealing, whilst the rest of the sites were overseen by the Divisional Director of Nursing. Staff told us they were confused by this situation about what their line of escalation was and what their job roles fully entailed with fragmented communication and a lack of governance meetings at department level due to the lack of clinical leads.
- There was a lack of visibility of the executive team reported by staff other than on one of the care of the elderly wards despite the executive team stating they did regular walk rounds and weekly bulletins.
- Clinical leads were in place at site level in each department but not at divisional level. This meant consultants were feeding straight back to the divisional clinical director or medical director with any concerns. However a plan was in place to appoint clinical leads in each department.

Culture within the service

- There were some aspects of poor morale of staff on the medical wards. Senior staff in care of the elderly said they perceived themselves to be 'marginalised' compared to A&E and the acute medicine teams. However, there was team spirit between the staff.
- Senior staff acknowledged staff were anxious due to not knowing what the future at EH was going to be. Staff that had come from Northwick Park to take on managerial roles were trying to be inclusive and supportive to their staff and that this had helped the team dynamics.
- Overall sickness was 3.5%. Staff told us the policy had recently changed to improve sickness rates by introducing actions earlier in a sickness period.

Staff engagement

- Monthly staff forums took place with the executive team although very few of the staff we spoke with had attended one.
- Staff said there was a lack of communication at divisional level with information not coming down plus some degree of having to do things only the way staff at Northwick Park wanted.

Innovation, improvement and sustainability

- A learning from practice meeting was scheduled for November in specialist medicine which all staff were invited to.
- Cardiology investigation facilities at Ealing were good for a hospital of this size but it was noted that many of the consultants had joint appointments at hospitals other than Northwick Park and the hospitals strategy for these services in the future was not made clear to us.
- Most of the cost improvement programme targets were not on target to be achieved.

Surgery

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

Information about the service

The number of surgical procedures at Ealing Hospital between January to December 2014 was 9,742. Day surgery was the main area of activity, at 53%. Emergency surgical procedures contributed 33% of the total and the remaining 14% was elective surgery. General surgery was the main specialty, at 56%, followed by trauma and orthopaedics (23%), urology (16%) and other specialties at 5%.

Surgical specialties include; ear nose and throat (ENT), a full orthopaedic and trauma service with the exception of complex spinal surgery, maxillofacial and oral surgery, and ophthalmics. The vascular surgery department provides diagnosis and management of carotid disease, aneurysmal disease, peripheral arterial disease, critical ischemia of the leg and venous disease.

Within the surgical directorate at Ealing Hospital, there are three wards, including; ward 7 South, which has 34 beds and is designated for trauma and orthopaedics, ward 7 North, which has 30 beds and cares for patients mainly with colorectal, upper gastrointestinal, urology and some gynaecology problems. Brunel day surgery ward has 22 beds. There are five operating theatres and a separate endoscopy department with ten beds, three cubicles and two procedural rooms. The six bed recovery department is managed by the Intensive Care Unit.

Pre-admission assessment services were provided at the location.

We visited all wards, theatres and endoscopy on 21 October 2015, during which we spoke with 40 staff including, doctors across various grades, nurses, operating department practitioners, healthcare assistants and allied health professionals. We reviewed 13 patient treatment and care records and spoke with 11 patients. We made observations of the environment, staff interactions and checked various items of equipment.

We undertook an unannounced visit to theatres and Brunel Ward on 4 November, where we spoke with three staff and two patients.

Surgery

Summary of findings

Patient safety checks in the Endoscopy department were not taking place using the World Health Organization (WHO) Surgical Safety Checklist. In addition, the arrangements related to surgical instrumentation and availability of technical equipment was not always ideal.

Staff had a good knowledge of the issues around capacity and consent but there was lack of assurance that staff had received Mental Capacity or Deprivation of Liberty Safeguard training.

The surgical risk register did not always identify the specific location of risks. Dates for resolution of risks had not always been stated.

The recovery area within theatres was not able to cope with the level of activity. Furthermore, the area used by children had not been designed or planned to take into account their needs.

Patient surgical outcomes were monitored through audit and required improvements had been noted for hip fracture patients and those having an emergency laparotomy. The hospital audit results were mixed when compared with England averages. Some national audits were not completed and some that were had data missing in parts.

Referral to treatment times were not being met in some surgical specialties, such as, general surgery, trauma and orthopaedics, urology and oral surgery. Theatres were not always effectively utilised and operating sessions started and finished later than planned, which impacted on patient discharges.

Staff reported positively on their immediate line managers and demonstrated a commitment to the delivery of high quality patient care. Despite this, staff had been affected by recent changes following the merger of trusts and were struggling to understand the future direction of the service at this location. Directorate leaders were developing the surgical directorate strategic aims and demonstrated a commitment to delivering high standards across the surgical locations.

Staff had the necessary skills and experience to ensure safe and effective patient outcomes and were supported appropriately. Patients needs were assessed, treated and cared for in line with professional guidance, under the care of consultants. The multidisciplinary team and specialists supported the delivery of treatment and care. Patients reported positively with regard to the quality and standards of care they received from staff.

Where complaints were raised, these were investigated and responded to and where improvements were identified, these were communicated to staff. The governance arrangements facilitated the monitoring of risks, safety, patient outcomes and effectiveness of the service and information was communicated across all levels.

Surgery

Are surgery services safe?

Good

We rated safety in surgery as good. There were effective processes for reporting, investigating and learning from incidents. Staff were open and honest with people when things did not go as expected. Patient safety was prioritised and there were arrangements to manage patient risks and to provide additional interventions when needed.

Clinical staff adhered to infection prevention and control best practices and adhered to professional guidance around medicines.

Whilst there were areas of clinical staff vacancies, the staffing arrangements ensured the safe delivery of patient treatment and care. There were enough medical and nursing staff to keep patients safe at all times.

Staff received mandatory safety training. Staff handovers were well managed with key issues identified, recorded and actioned to ensure patients who were unwell were monitored and supported.

The recovery area did not have sufficient capacity to enable all patients to be recovered following their surgery.

The World Health Organization (WHO) Surgical Safety Checklist had not been implemented in the endoscopy service. Surgical instruments were not always readily available.

Incidents

- Nursing and medical staff were aware of the processes to follow in order to report adverse incidents or concerns. Staff who spoke with us understood their responsibilities to raise concerns, to record safety incidents, concerns and near misses, and to report them internally in order that they could be investigated and acted upon.
- Safety goals had been set with respect to a range of indicators. These included, safety around medicines, the completion of patient safety checks, staffing levels and safety related training. Targets were rated using a traffic light system of red, amber and green, and a performance dashboard was produced for each area. This enabled staff to see the monthly performance and cumulative results over time and also year to date. Results for ward 7 North indicated scores of between 80% and 100% for the patient safety quality indicators year to date.
- There had not been any surgical Never Events at the Ealing Hospital in the previous year up to the time of our inspection: “Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.”
- We reviewed evidence in the theatre department, which indicated the sharing of information with regard to a never event which occurred on another location within the trust. We saw a full review of the situation had been conducted and the action taken to minimise reoccurrence. A staff log had been completed to indicate when staff had read the revised policy, which had been written in response to the event. Staff had also attended half day governance study sessions, during which there had been shared learning related to the never event. There was an awareness within other nursing areas of the never events which occurred on other sites.
- The Serious Incident Framework 2015/16 describes Serious Incidents (SI) in health care as adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Between August 2014 and July 2015, there were seven reported SI’s in the surgical directorate at the Ealing Hospital site. These included three pressure ulcers at grade three, two further pressure ulcers which met the SI criteria, one surgical invasive procedure and a cardiac arrest, which followed a short time after the removal of a central line. The patient safety and quality indicator for ward 7 North showed no reported serious incidents for the year to date. There was a full investigative process for SI’s, which included root cause analysis, conclusion and shared learning. We do not have comparison data sufficient to indicate incident reporting rates in surgery but trust wide there is a lower level of incident reporting per 100 admissions at 7.1 than the England average at 8.4.
- There was a multidisciplinary medicines safety forum across all trust sites. Medicines incidents were discussed

at this forum, and learning was shared across staff pharmacy and nursing staff in a variety of ways, such as emails, handover meetings, medicines bulletins, information published on the intranet.

- Staff were open and honest with relevant patients or relatives when serious incidents had occurred. We reviewed written correspondence in which the relative of a patient was invited to attend a meeting with relevant staff in order to be appraised of the outcome of a SI investigation.
- Nursing staff reported being made aware of incident investigations and such information was shared at monthly ward meetings and sisters' forums. Two members of nursing staff described independently the learning and actions taken from one SI that had occurred on ward 7 South.
- From our discussions with a wide range of nursing staff, there was a good understanding about being open and honest with people when things had gone wrong, although Nursing and medical staff had a variable level of awareness of the term 'Duty of Candour'. This sets out the premise that as soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred, a health service body must notify the relevant person that the incident has occurred, provide reasonable support to the relevant person in relation to the incident and offer an apology.
- We found that staff adhered to the principles of the duty of candour. We reviewed an example of a written communication sent to a patient, in which they were invited to meet with representatives of the trust in order to receive feedback with regard to an adverse incident. We noted the letter contained an apology.
- The number of surgical site infection rates following hip replacement surgery at Ealing Hospital was reported to us as having been 16 for the period October to December 2014 and six between January and March 2015. The number of patients who developed a surgical site infection following knee replacement was reported to have been 29 and 28 across the same periods respectively.
- We noted from the terms and reference of the Mortality and Morbidity (M&M) meetings that information was to be reported to the Divisional Governance Meetings and agreed specific recommendations and findings would be escalated to the Clinical Directors, the Divisional Clinical Director, Divisional Manager and Divisional Head of Nursing for Surgery or Executive meetings where appropriate. We were informed by the surgical directorate lead that M&M meetings had been increased and took place every two weeks in each directorate. They told us soft intelligence, along with the M&M process enabled identification of issues and action to be taken. For example, we were made aware of action taken in response to the death of four patients following a specific procedure over a period of eight months.
- Our review of minutes from M&M meetings indicated that information discussed fed into service improvement and learning from specific cases was made clear. For example, we saw a formal presentation for the joint surgical and anaesthetic mortality and morbidity meeting for emergency surgery. There was evidence of discussion of the patient treatment pathway and various complications, along with interventions and root cause analysis.

Safety thermometer

- The NHS Safety Thermometer scheme had been used to collect local data on specific measures related to patient harm and 'harm free' care. Data was collected on a single day each month to indicate performance in key safety areas, such as hospital acquired pressure ulcers, patient falls and urinary tract infections related to having a urinary catheter. This data was collected electronically and a report produced for each area.
- At Ealing Hospital the prevalence rate of pressure ulcers, patient falls and catheter related urinary tract infections remained low during the period of June 2014 to June 2015. We observed results displayed on ward areas and saw for example, in the year to date, there had been eight patient falls on ward 7 North, none of which had resulted in the declaration of a serious incident, such as a fracture. There had been two hospital acquired pressure ulcers graded as two to four year to date on this ward. Of these, none had been declared as avoidable. There were no reported urinary catheter related urinary tract infections on ward 7 North and no patients who had developed a deep vein thrombosis. There had not been any incidents in these categories on Brunel Ward.
- Care bundles were in place to support staff in the delivery of care and for managing such areas of risk associated with reduced mobility, urinary catheters and falls.

Surgery

Cleanliness, infection control and hygiene

- In surgical wards, operating theatres and endoscopy areas, we found the environments were clean or were being attended to by domestic staff at the time of our visit. Standards of cleanliness and hygiene were maintained by dedicated staff as part of a service level agreement with an external provider. Monitoring of standards was carried out by the service provider, for example the supervisor inspected theatres daily and staff advised the wards were checked weekly. We reviewed monitoring results for April and May 2015 and noted a 98% score with regard to cleanliness in theatres.
- Domestic staff had been provided with guidance on required cleaning standards, instruction on the frequency of cleaning and procedures. National colour coded cleaning equipment was provided to domestic staff and they were seen to carry out their duties safely, wearing personal protective equipment (PPE). Information was displayed on wards about the frequency of cleaning, which was based on a risk assessment.
- We reviewed a number of infection control policies and found up to date and reliable information to support staff in the prevention and protection of people from a healthcare-associated infection. We saw that staff followed safe practices as outlined in the respective policies, such as wearing PPE, dress code and disposal of clinical waste. In addition, we saw that staff had ensured items of equipment used by patients, such as commodes, blood pressure cuffs and infusion devices were clean and labelled as such.
- Nursing staff confirmed that there were link nurses for infection control and that these individuals had a responsibility for attending meetings and cascading information and training to staff. The monitoring of staff compliance with infection prevention and control standards was also part of their role. This included hand hygiene compliance. For example we saw, on the quality board presented on ward 7 North, a hand hygiene compliance rate of 100% for October 2015. In theatres we saw a compliance rate of 97%.
- There was access to adequate hand washing facilities and decontamination hand gel was readily available at the point of care. We observed all nursing, medical and allied health professional staff washing their hands immediately before and after every episode of direct contact or care.
- We saw staff following to safe practice with regard to isolating people who had been identified as having an infection. Signage was in place on the doors to isolation rooms to alert anyone visiting or staff entering of the actions to be taken.
- We noted on ward 7 South, which was a mixed trauma and orthopaedic ward, that many of the patients were from general surgical specialties. Potential infection risks were minimised as 'clean' elective surgery patients were separated pre-operatively from people requiring emergency surgery.
- Patients' records reviewed confirmed they had been screened for Meticillin-Resistant Staphylococcus Aureus (MRSA) during pre-assessment or as soon after admission as possible, where they had been admitted as an emergency. We noted from patient safety and quality monitoring that MRSA screening was reviewed on an on-going basis. Results for ward 7 North indicated MRSA screening to be 100% year to date. On ward 7 South MRSA screening had been 98% up to July 2015 and on Brunel Ward compliance with screening was 99%.
- Patients received information in the pre-operative phase about showering and hair removal, hand jewellery, artificial nails and nail polish. Checks were made as part of the patient's preparation for theatre and prior to escorting to theatre. Where specific preparation was required for a surgical procedure, information was provided by staff.
- Theatre staff followed NICE guidance with respect to theatre wear and dress code when leaving the operating area. They observed best practice during each stage of the intraoperative phase including hand decontamination, application of surgical drapes, sterile gowns, gloves, and antiseptic skin preparation.
- Patient care records reviewed by us demonstrated where staff had followed the specified procedures necessary for the safe insertion and maintenance of intravenous devices. Staff had recorded when devices had been inserted, monitored the site of insertion and recorded when they had been removed. On-going compliance with the safety indicator related to peripheral cannulas was noted to be 98% for ward 7 North in July but no results had been submitted for ward 7 South.
- Performance data for surgical wards did not contain information about infection rates. However, we reviewed information displayed in ward 7

South,which indicated there had not been any Clostridium Difficile or MRSA on ward 7 South for the year to date. Similarly there had not been any reported cases of either infections on ward 7 North or on Brunel Ward.
- We saw that all staff observed bare below the elbow practice on the wards.

Environment and equipment

- Wards ranged in size and layout but were noted to be set out in a manner which ensured people were safe. Wards were accessed by staff using a swipe card or buzzing through to the reception in a visitor's case.
- The operating theatre department had five separate theatres, with associated anaesthetic rooms and the required separate clean preparation and dirty areas. There was Laminar air flow in three of the theatres.
- The six bedded recovery area was managed and staffed by the Intensive Care Unit. Theatre staff reported facing a "bottleneck" regularly as two or three of the recovery beds were used by High Dependency Unit patients. This resulted in patients having to be recovered in theatres. Furthermore, children were recovered in the same area as adults.
- The endoscopy department had not achieved Joint Advisory Group (JAG) accreditation as a result of a number of factors, for example, not being able to meet ventilation requirements in the endoscope decontamination room. We found that staff were having to keep the fire exit door open to facilitate ventilation and improve the ability of staff to work there. (JAG Accreditation is the formal recognition that an endoscopy service has demonstrated that it has the competence to deliver against the measures in the endoscopy Global Rating Scale (GRS) Standards.)
- A number of risks related to endoscopy services had been identified on the risk register, although it was not clear which locations the risks related to. Actions had not always been identified and there were no time lines stated for resolution.
- Within endoscopy, each of the two procedure rooms had an endoscopic stack. Staff told us the stacks were serviced by the electrical engineering department, and they held the records of such actions. The endoscopes were serviced under a service contract by the company and labels were attached to indicate when the service had taken place.
- We observed that staff working on wards and in theatres were following safe arrangements for managing the different types of waste and clinical specimens in order to keep people safe.
- We looked at equipment check records. Blood pressure machines, infusion devices and hoists had evidence of safety checks having been completed.
- Surgical equipment including resuscitation and anaesthetic equipment was available, was fit for purpose and had been checked in line with professional guidance. However, surgeons raised concern with us that there was inadequate stock of some "bread and butter" items of equipment, such as endoscopic gastro-intestinal cartridges, and they were frequently asked by theatre staff to "make do" with an alternative.
- Checks of essential theatre equipment had been undertaken and there was access to emergency items of equipment. There was sufficient supply of drapes, gowns, suction and other items used for the safety of patients in theatres.
- Single use equipment was available on wards and in theatres. Sterile surgical instruments used in theatres were processed at a centralised centre external to the hospital. Surgeons reported inadequate supply of other equipment items, such as retractors and advised that sets came back from the decontamination unit incomplete. During our visit we found one item of instrumentation missing from the tray inspected before the start of surgery. Such problems resulted in staff having to locate and open additional sets, which had delay and cost implications. This incident had been reported via the Datix process and we saw this on formal documentation provided.
- There were items of equipment available in theatres for the safe positioning of individuals who were outside of standard weight ranges. Operating tables were suitable for individuals up to the weight of 250 kilograms.

Medicines

- Nursing staff informed us that pharmacists and pharmacy technicians visited the wards daily Monday to Friday in order to review all prescriptions, including new admissions and those who were to be discharged. Medicines cupboards and 'patient pods' used for patients' own medicines were topped up daily.
- We checked the process for obtaining, prescribing, recording, handling, storage and security, dispensing, safe administration and disposal of medicines on wards

and in theatres. The arrangements for managing medicines and medical gases ensured people were kept safe. Medicines were stored safely in lockable cabinets, which were secured to a wall when not in use. Medicines cupboards were locked and only accessible through a secure keypad door. Fridge temperatures for storage of temperature controlled medicines had been carried out and action taken when the range was outside safe levels.

- In one anaesthetic room, we noted the drugs for the whole surgical list for the day had all been prepared in advance. This was not best practice and posed risks of drug errors arising. Otherwise medicines used in the anaesthetic room and theatres were seen to be prepared safely, with labels attached to syringes and checks were undertaken prior to administration. Medicines given to patients were recorded on anaesthetic charts and prescription records in the theatre area.
- Staff on wards wore red tabards indicating they were undertaking medicines rounds and should not be interrupted. We saw that staff took time to check the prescription chart when preparing medicines and prior to administration to make sure that the patient was correctly identified.
- We noted in the minutes of the Ealing Hospital Medicines Safety Group held on June 15 2015, errors which occurred in the surgical directorate had been discussed and reviewed. Information provided had also included associated guidance, which had been communicated by way of patient safety alerts.
- There was evidence of good antibiotics stewardship. The antibiotics section of the Ealing hospital drug chart had been designed in such a way that it ensured that a doctor reviewed the need for the antibiotic after three days, and again after seven days. The indication of the antibiotic was required on the drug chart, as well as the name of the staff member from the microbiology team that was involved in the decision to prescribe the antibiotic. Gentamicin and vancomycin both had their own drug charts, which prompted the clinicians to take the relevant drug monitoring levels before the medicine was continued. Point prevalence studies (an assessment of the use of antibiotics and level of compliance with the antibiotics guidelines) were conducted every six months, and the outcome data was then fed back to the antibiotics stewardship group and the Drugs and Therapeutics Committee.
- Our review of patient records demonstrated that allergies had been clearly documented in patient prescriptions. Prescription records were clear and evidenced the different routes, times and frequency of medicines to be given, as well as those that were prescribed on an as required basis.
- We observed nursing practice around the protocols for administration of controlled drugs (CD) as per the Nursing and Midwifery Council – Standards for Medicine Management. Staff followed procedures correctly and ensured that all necessary safety checks had been carried out prior to the patient being administered the CD.
- Checks on the ward and theatre CD registers demonstrated safe record keeping with regard to all aspects of CD management.
- The medicines department had undertaken regular audit of the management of controlled drugs. The audit results for Ealing Hospital (June 2015)indicated that adherence to CD standards was above the trust target and achieved 97%. It was noted this was a slight improvement on the previous quarter results. A number of surgical areas were noted to be 100% compliant, including main theatres, recovery, endoscopy and theatres one to seven. Where corrective action was required this had been defined, with responsible persons identified and agreed timelines for resolution.
- The use of summary care records (SCR) had been implemented at Ealing hospital to assist with the completion of medicines reconciliation, which both pharmacists and pharmacy technicians were trained to carry out. The medicines management technicians were also trained on conducting medicines reconciliation and they were accredited via London Pharmacy Education and Training.
- Following the National Patient Safety Agency (NPSA) alert on missed doses, the trust had implemented a number of strategies in an attempt to manage and reduce the number of missed doses. For example, pink stickers were placed in patient notes to communicate the dose missed and the reason for the omission; medicines safety bulletins; and shared learning at meetings.
- Overseas adaptation nurses who were awaiting their nursing registration pin explained how they had undertaken a drugs calculation test and, once they had their pin, they would complete competency based training related to medicines management.

- We checked the arrangements for storage and management of substances, which came under the control of substances hazardous to health (COSHH). On ward 7 South, nursing staff did not know when checks had been done on the COSHH cupboard. Matron advised a risk assessment had been carried out on the COSHH arrangements last year on ward 7 North.

Records

- We found from our review of patient treatment and care records that a standard approach was used for these, although there was a slight variation in day surgical documents when compared with inpatient records. Care plans were not individualised but were generic, covering a range of nursing assessment related to activities such as nutrition, washing and dressing, sexuality and body image, sleeping, mobilising and disabilities.
- Documentation completion by nursing, surgical staff and allied health professionals was mostly completed to a good standard. Information was legible and enabled staff to understand and deliver the required treatment and care to their patients.
- Risk assessments were part of the patient treatment and care record and included pressure areas, nutritional, patient handling, falls and bed rails assessments. Information recorded assisted nursing and other staff to understand what was expected of them in terms of supporting the delivery of care; however, there was no additional information to indicate patient's specifics wishes, preferences and choices. Records were mostly accurate, complete, legible, up to date and stored securely.
- Essential information to keep people safe had been identified and acted upon, for example, the use of bed rails or specialised mattresses. Information about this was communicated to staff in the care records and reinforced at handover between shift changes.
- Where patients were having their fluid intake and output monitored, we found that 80% of the charts for recording such information had been completed fully. The totalling of intake and output was missing in two out of 10 records reviewed.
- Where people had attended pre-operative assessment, the information gathered at this appointment had been recorded on the nursing record and was made available for the subsequent admission.
- We were told by a matron that spot checks were undertaken on patient records in order to assess quality of records completion. We did not see any formal documentation to support this.

Safeguarding

- A formal safeguarding policy was provided to staff, which outlined the underpinning principles, responsibilities and the governance and reporting structures. This was found to be accessible on the hospital intranet.
- We noted from minutes of the adult safeguarding meetings that there was multidisciplinary representation. Discussion covered a range of relevant matters, such as domestic violence, training, dementia, mental capacity and deprivation of liberty safeguards.
- Nursing staff advised they were required to complete levels one and two safeguarding training on-line. Face to face training was provided for those who were required to have level three training. An overseas adaptation nurse told us they had not completed any safeguarding vulnerable adults training. Despite this they had a good knowledge and understanding around the subject.
- There were no lead nurses for safeguarding on ward 7 South; however, staff confirmed there was access to the safeguarding team. In addition there was access to the Caldicott guardian based at Northwick Park Hospital.
- Safeguarding alerts were said by a member of nursing staff to be added to the electronic information system.
- Training rates for nursing staff for safeguarding adults level two were 100% on ward 7 North. On Brunel Ward it was 85.7% and in theatres there were three staff out of 28 (10.8%) identified as requiring safeguarding adults training.
- In our discussion with clinical staff they were able to demonstrate their awareness of safeguarding and understood their responsibilities to adhere to safeguarding policies and procedures, including acting on possible concerns.

Mandatory training

- Nursing and theatre staff confirmed there was an expectation to undertake mandatory training and that staff had to take responsibility for completing this. Subjects included for example; Infection prevention and control, health and safety, manual handling and resuscitation.

- Ward 7 South staff reported finding it difficult to complete the required mandatory training due to ward activity demands. Mandatory training compliance was reported to be 46% year to date on ward 7 South. In theatres we noted 69% of staff had completed the required training and the figure was the same on Brunel Ward. A compliance rate of 87% had been achieved on ward 7 North. 91% of staff had completed training in infection control, 97% in conflict resolution, 89% in equality, diversity and human rights and 85.29% in resuscitation.

Assessing and responding to patient risk

- Our review of patient records demonstrated staff had completed comprehensive risk assessments with respect to falls, nutritional needs and venous thromboembolisms (VTE). In addition, patient assessment included identification of potential risks associated with having a general anaesthesia.
- Within the patient records we reviewed we were able to see evidence that staff were complying with the National Institute for Health and Care Excellence (NICE) quality standard related to venous thromboembolism (VTE) risk assessments and management. We found that all patients, on admission, had received an assessment of VTE and bleeding risk. Where interventions were required, these had been acted upon, including the use of prophylaxis medication and support stockings. Compliance with VTE checks had been monitored and we saw a 100% compliance rate year to date on ward 7 North, Brunel Ward and in theatres.
- Pre-operative assessments included a comprehensive review of the patients previous and current health problems and needs and physical assessments had been carried out in line with guidance on pre-operative assessment for both day case and inpatients.
- We noted that risks were managed positively through the appropriate use of interventions. For example, this included ensuring high risk patients who needed surgery were not admitted as a day case. Where required, patients were seen by the tissue viability nurse in order to ensure potential risks to their skin were managed effectively.
- Ealing Hospital had a patient observation and escalation policy, which was noted to reflect the guidelines from the National Institute of Clinical Excellence (NICE) CG 50, the National Patient Safety Agency (NPSA) (2007), the Department of Health; Competencies for Recognising and Responding to Acutely ill Patients in Hospital (2009) and the Royal College of Physicians; Standardising the Assessment of Acute Illness Severity in the NHS (2012). We noted staff completed the required observational tool, known as NEWS. Resulting scores from this enabled staff to alert medical staff where a patient's condition was deteriorating. We saw evidence in patient notes of the responsiveness of medical staff in such a situation and the actions taken to manage associated risks to the patient's wellbeing.
- Compliance with the completion of the NEWS was monitored and we saw for example on ward 7 South year to date a compliance rate of 93%. This ward did less well in May 2015 (83%) and September 2015, (75%).
- In conjunction with the NEWS, staff completed a specific reporting tool, known as 'SBAR'. This recorded details about the situation, background details about the patient, their assessment, such as blood pressure and respiratory rate. The final section related to recommendations, for example, the need for immediate attention.
- Nursing staff reported the Critical Outreach Team as being responsive when their advice or interventions were required.
- Staff followed a sepsis pathway for the management of patients whose condition met the criteria.
- We noted from patient records and observed staff undertook two hourly 'comfort rounds', as they were known. These provided an opportunity for nursing staff to check the status of the patient, their comfort and wellbeing and to update risk assessments accordingly.
- We observed theatre staff following the 'Five Steps to Safer Surgery', which included team brief, sign in, time out, sign out and debrief. Staff confirmed the 'Brief', which was the first part of the 5 steps to safer Surgery, World Health Organization (WHO) Surgical Safety Checklist commenced at around 8:15am in every theatre. Theatre Staff were all aware that an operating list would not commence unless a 'Brief' had taken place. Surgeons and anaesthetists were said to arrive a few minutes later than 8:15am, as they were busy seeing and consenting patients in the theatre admissions area. The consequence of this was that the start time of operating list was later than planned, but there was a

firm understanding that conducting the 'Brief' was mandatory. The process was led by the operating surgeon and with the full attention of the entire team in theatres.

- Whilst we did not witness if the final stages of the process, 'Sign Out' or 'Debrief' was carried out, we noted from the compliance monitoring data displayed in theatres on the notice boards a good standard of practice and the overall performance was well over 90%. The process identified as not yet fully embedded in practice was the 'Debrief'. We were told that this was due to the fact that lists over ran. The theatre and general manager were aware of this and recognised the need to work with the teams to embed this element.
- We found in our review of patient records evidence of each stage of the five steps of safety mostly having been undertaken.
- In the Endoscopy department, there was no evidence of a WHO Safety Checklist, and on further investigation with the Endoscopy Manager and Consultant surgeon this was confirmed.
- There was access to advice following discharge from Brunel Ward. We reviewed the information which was provided to patients and found there were details of who to contact and the telephone number for the first 48 hours after leaving hospital.
- American Society of Anaesthesiologists (ASA) fitness assessments for anaesthetics were completed on all patients prior to surgery and those classified as an emergency were identified accordingly.

Nursing staffing

- Staff told us a safer staffing tool was used periodically to assess the required staffing levels and skill mix. This was said to have been completed most recently as July 2015 on ward 7 North. The results had indicated acuity as being higher in the last two weeks than the first half of the month. Information from the tool was said to have been sent to the auditor and had resulted in improved staffing, reducing the ratio of patients to nurse from one to 10, down to one to nine. Performance indicators for ward 7 North demonstrated a nurse to patient ratio of 1:8.6 year to date.
- We reviewed a staffing report for ward 7 North, which required completion on a daily basis. The information reported planned staffing by registered nurse and healthcare assistant per shift and where bank or agency staff were used. We noted from the information three agency nurses, 62 bank nurses and 20 bank healthcare assistants had been used in the month of September 2015.
- Rotas provided to us for wards 7 North and South indicated the arrangements for staff cover, with balance of skill mix across day and night shifts. We saw there was a band six nurse taking charge when a more senior nurse was not on duty.
- We observed on our visits to the wards the expected and actual staffing levels displayed for day and night shifts. Staffing levels were noted to match the requirements on the day of our visit on ward 7 South but the staffing on ward 7 North had been depleted by sickness of one healthcare assistant. On the Brunel Ward staffing levels matched expectations.
- We were made aware of high vacancy rates by nursing staff; for example, on ward 7 South there were nine band five nurse vacancies. These posts had been advertised and four or five of them were expected to be filled once professional pin numbers had come through for the overseas adaptation nurses. On ward 7 North, the nurse vacancy rate was at 20%, with a ratio of one nurse to nine patients achieved with the staffing arrangements in place.
- In order to ensure safe staffing levels, there was a reliance on contracted staff undertaking extra hours as 'bank staff' in their own time. The ward also used two regular agency nurses, one for days and one for nights. Induction and local orientation was completed for agency staff.
- Staffing numbers and skill mix was cited as a problem on ward 7 South and in particular the protracted recruitment process and needing to have cover for sickness signed off, which was said to be time consuming.
- The interim theatre manager advised us that staffing establishment had been reviewed and reductions had subsequently resulted. Four staff were allocated to each theatre (previously five), and they provided the required roles to support the surgeon and anaesthetists. There were 12 vacancies at the time of our visit but recruitment was reported to be difficult as a result of "bad press" around the decommissioning of services. Cover for these vacancies was achieved by the use of agency staff, and such staff were required to complete a local induction and orientation.

- There were 16 staff working in the endoscopy department, which included two administrative staff. One vacancy remained at the time of our visit.
- The handover of patient information took place at each shift change and included details about each patient condition, specific tests or investigations needed and their progress.

Surgical staffing

- Surgical staffing skill mix at Ealing hospital was made up as follows: 30% were consultant grade staff, 18% middle career, that is those with at least three years as a senior house officer or a higher grade in a chosen specialty. Specialist registrars made up 26% and there were 24% junior doctors in foundation years one or two (F1/2).
- There was a consultant on duty during day time hours and on-call at nights. Surgery was consultant led.
- The FY1 and FY2 doctors (Foundation Year 1 and 2) were assigned to a consultant and an area of surgery, such as general surgery or orthopaedics. In our discussion with a FY2 doctor they perceived themselves to be very well supported by the specialist registrar (SpR) and consultant surgeons and anaesthetists, all of which were said to be easily accessible.
- There was full surgical medical cover during the day. A general surgical SpR was resident at nights , whereas the trauma and orthopaedic SpR was home based and on call.
- Surgical staff shift changes enabled the communication of relevant patient information so that on-going treatment and care could be delivered safely.
- We observed ward rounds taking place on each area visited and there was a doctor's presence on each ward.
- Information provided to us indicated the speciality and frequency of locum surgical staff. For example we noted a whole time equivalent consultant for head and neck was being used until there was agreement on the service model and a substantive post was advertised. We were unable to tell from the information entered on the record the number of locums used by location. A consultant locum was on ward 7 South when we visited. They were very 'hands on' and knew their patients in detail. This individual commented positively on the level of patient safety.

Major incident awareness and training

- A major incident protocol was available to staff to access and we noted actions to be taken were displayed on ward 7 South. We saw action cards were available to staff in theatres.
- We reviewed the protocols for deferring elective activity to prioritise unscheduled emergency procedures and found there was a formal process for staff to adhere to. This included stopping elective work if there was a need to open a second emergency theatre.

Are surgery services effective?

Requires improvement

The hospital audit results were mixed when compared with England averages. Some national audits were not completed and some that were had data missing in parts.

Patient surgical outcomes had also been monitored by local audit. Patients with a hip fracture were not always admitted to orthopaedic care within four hours and surgery was not always performed on the day of admission or the following day.

The National Emergency Laparotomy Audit for 2015 indicated four areas where patients care was not met.

Patients having non-elective surgery stayed on average slightly above the England comparator, at 5.4 days. Length of stay was higher for trauma, orthopaedics, and urology. For patients having non-elective general surgery the length of stay was less than the England average.

Staff had a good knowledge of the issues around capacity and consent but we did not have assurance that staff had received Mental Capacity or Deprivation of Liberty Safeguard training.

Patients had been assessed, treated and cared for in line with professional guidance. Consultants led on patient care and there were arrangements to support the delivery of treatment and care through the multidisciplinary team and specialists.

The majority of patients reported effective pain management and monitoring.

The nutritional needs of patients had been assessed and patients were supported to eat and drink according to their needs. There was access to a dietitian and the speech and language therapy team. Special medical or cultural diets were catered for.

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

Evidence-based care and treatment

- Our observational checks of patient records confirmed compliance with NICE QS66 Statement 2: Adults receiving intravenous (IV) fluid therapy in hospital are cared for by healthcare professionals competent in assessing patients' fluid and electrolyte needs, prescribing and administering IV fluids, and monitoring patient experience. We saw that intravenous fluids and medicines had been prescribed by a doctor. Records of administration had been completed and recorded on prescription charts and fluid balance forms.
- Patients who were assessed to be at risk of VTE had been prescribed and administered with VTE prophylaxis in accordance with NICE guidance.
- Nursing and medical staff assessed the needs of the patients on admission and throughout their hospitalisation. Treatment and care was planned and delivered in line with evidence-based, guidance, standards and best practice. Monitoring of patient safety outcomes enabled the surgical directorate to assess such standards were being delivered.
- We did not see any evidence to suggest discrimination on grounds of age, disability, gender reassignment, pregnancy and maternity status, race, religion or belief and sexual orientation in making care and treatment decisions.
- Technological equipment was used to monitor patient well-being and enhance the delivery of effective care and treatment in theatres, recovery and on wards.
- We found the surgical services were managed in accordance with the principles outlined in National Confidential Enquiry into Patient Outcome and Death (NCEPOD) classifications around access to emergency theatres and the Royal College of Surgeons (RCS) standards for unscheduled surgical care. For example, theatre 5 was used for emergency surgical patients and patients were booked via the completion of a proforma and assessed and prioritised by an anaesthetist. The classification was done at the time of the decision to operate and when the theatre was booked. The correct classification was supplied to the theatre co-ordinator when the patient was booked so an appropriate priority was assigned to the case. The classification was recorded in the patient's case notes.
- We spoke with an anaesthetist about accessing and following guidelines from the Association of Anaesthetists of Great Britain and Ireland (AAGBI). We were shown an example of the guidance, with regard to managing Malignant Hyperthermia. This was held on the individual's mobile phone and we were told this was common practice. There was access to the required medicines in the event that such a case occurred.
- We found there was an enhanced recovery programme, led by the orthogeriatrician and supported by a trauma nurse co-ordinator, which ensured the appropriate pathway was followed by patients who received treatment and care following a fractured neck of femur. A discharge co-ordinator was responsible for liaising with occupational therapists and physiotherapists with regard to patient recovery and planning for discharge home or for on-going care.
- Professional guidance was followed with respect to recording and management of medical device implants. Data was submitted to the national joint register, subject to patient agreement.
- Pre-operative tests were undertaken in accordance with best practice guidance. Pre-operative assessment included assessment of patient's physical well-being and staff provided advice with respect to optimal fitness for surgery. This included advice related to diet, medicines, mobility and instructions regarding preparation for surgery.
- Steps were taken within the operating theatre to minimise the risk of patients developing a surgical site infection. We saw attention was given to the correct procedures of preparing the patients incision site and post-operative wound dressings.
- The post-operative recovery of patients focused on supporting them to be as mobile as possible and to regain their independence. The resumption of normal eating and drinking was encouraged where appropriate and unless a clinical indication, drips and urinary catheters were avoided.

- We noted there was a programme of audit which set out the areas of focus and expected completion date of March 2016. The anaesthetic audit at Ealing Hospital included Procedural Sedation in Adults, Sprint National Anaesthesia Project (SNAP) and a medical records audit. Orthopaedics were auditing compliance with British Orthopaedic Association, and BOAST 1 Version 2 Neck of Femur (NOF) Guidelines adherence, medical records, and the National Joint Registry (NJR - hip, knee and ankle replacements). Other general surgery audits included the National Comparative Audit of Patient Blood Management in Surgery, National Inflammatory Bowel Disease.

Pain relief

- We found from our review of patient records, which included the completion of comfort rounds and observational tools, patients had their pain assessed. A scoring system was used to rate the level of pain. There were pictorial signs for expressing pain available to individuals who had learning disabilities or a cognitive impairment.
- Staff said that they had access to the pain team when required. This included anaesthetist advice at weekends. We found there was consideration of the different methods of managing pain, including patient controlled analgesia pumps.
- The fractured neck of femur analgesia pathway included use of the fascia iliaca compartment block for pain relief, where patients were suitable.
- We observed and heard staff asking patients if they had any pain. We also saw them act on this where patients indicated they had pain. Pain relief, including controlled drugs were only administered after nursing staff checked patient details against their prescription.
- Patients reported mixed experiences of having their pain needs addressed, although the majority were satisfied with their pain management. However, one patient told us they had waited for pain relief as staff were busy. Another patient said whilst they had been given pain relief, staff did not check if this was effective or not.
- Pre-operative assessment included a review of existing pain and current treatment for this.

Nutrition and hydration

- We observed risks assessments in place for nutritional needs and these had been reviewed as part of the progress reports.
- Where patients required intravenous fluids these had been prescribed by the doctor. We saw that fluid balance charts were provided and used to monitor the patient input and output.
- Patients were not fasted for lengthy periods prior to theatre, although it was noted in day surgery (Brunel Ward) there were times when patients did not go to theatre as early as expected and therefore they went some time without food.
- Anti-nausea medicines had been prescribed for patients who experienced nausea and vomiting after surgery.
- There was access to dietitian services pre and post operatively, along with support from the speech and language therapy (SALT) team for patients who had difficulties in swallowing. Although dietitian's were not available on-site at weekends, there was guidance related to nutritional feeds on the intranet.

Patient outcomes

- Audit results for the service were mixed when compared with England averages - some better, some worse. They were not consistently better than average results for England. Some national audits were not completed and some that were had data missing in parts.
- The service was reviewing the effectiveness of care and treatment through local audit and national audit. The National Bowel Cancer Audit results for Ealing Hospital in 2014 indicated a good case ascertainment rate of 96%, slightly above the England average of 94%. The location did better than the England average for having computerised tomography (CT) scans reported, 93.9% compared with 89.3%. Areas where they scored slightly less than the England average related to patients being seen by a clinical nurse specialist (84.9%) and patients being discussed at the multidisciplinary team (98.5%).
- The Lung Cancer Audit results for Ealing Hospital for 2014 indicated that 98.5% of patients had been discussed at a multidisciplinary meeting, which was above the England and Wales average of 95.6%. The percentage of patients receiving a CT scan prior to a bronchoscopy was less than the England and Wales average at 82.4%, compared to 91.2%.
- Ealing Hospital did not participate in the National Prostate Cancer Audit or the National Oesophago-Gastric Cancer Audit 2014.
- Ealing Hospital submitted data related to 94 hip and 155 knee joint surgical procedures to the National Joint Registry (NJR) so far in 2015. We noted they had also

performed two shoulder and one ankle replacement. Consent by patients to be included in the NJR was 100% year to date. Outcomes were as expected for knee procedures undertaken between April1 2014 and March 31 2015. There was no outcome data for the hip replacements available on the NJR.

- The National Hip Fracture Audit for 2013/14 indicated that 140 cases were submitted from Ealing Hospital in 2014. Of these five of the indicators performed worse than the England average. This included only 12.3% of patients being admitted to orthopaedic care within four hours, against the England average of 48.3%. Surgery was performed the day of admission or the following day in 65.7% of cases, compared to 73.8% England average. Falls assessment had been completed in 86.5% of cases, with an England average of 96.8%. Areas where Ealing Hospital performed better were with respect to patients having a bone health medication assessment, which was slightly above the England average at 97.6%. The number of patients who developed a pressure ulcer was less than the England average at 2.4%.
- Information related to patient hip fractures was submitted to the National Hip Fracture Database annual report 2015, (NHFD). We reviewed the annual report and noted 10.5 % of patients were reported to have been admitted to an orthopaedic ward within four hours. The London average was 29% and overall average 46.1%. The percentage of patients mobilised the day after surgery was 34.4%%, compared with a London average of 69.4% and overall average of 73.3%. The location performed better (above 90%) with regard to mental test assessments, preoperative medical assessment, a falls assessment and bone health assessment.
- Patient Reported Outcome Measures (PROMS), were responses from a number of patients who were asked whether things had 'improved', 'worsened' or 'stayed the same' in respect to four surgical procedures, (groin hernia, hip replacement, knee replacement and varicose veins). The majority of indicators for Ealing Hospital respondents suggested an improving picture when compared to the England average.
- Ealing Hospital was part of the North West London Trauma Network and had a shared aim of improving patient care and their outcomes.
- The trust's self-reported National Emergency Laparotomy Audit for 2014 indicated that the provision of facilities required to perform emergency laparotomy was unavailable for 10 of the 28 measures reported on. This included, for example, no details about the availability of a reserved operating theatre for emergency surgical patients 24/7; lack of information to confirm a minimum four tier EGS rota at all time; details about the availability of a critical care outreach team 24/7, and if there was a policy for anaesthetic seniority according to risk. There was no information about the pathways for enhanced recovery of patients and no details to indicate the responsibilities of the surgeon to formally hand over patients in person.
- The National Emergency Laparotomy Audit for 2015 indicated four areas where the proportion of patients for which each process of care was not met. This included the reporting of CT before surgery, pre-operative review by consultant surgeon and anaesthetist, presence of consultants in theatre, and assessment of patient over the age of 75 years by an orthogeriatrician.
- Between January and December 2014 the average length of stay at Ealing Hospital for elective surgical patients was slightly above the England average at 3.6 days, compared to 3.1. Patients having general surgery and urology generally stayed for fewer days, 2.8 and 1.9 respectively compared with the England average of 3.1 and 2.1 respectively. However, patients who had elective trauma and orthopaedic procedures stayed on average 5.1 days, compared to the England average of 3.1 days.
- Patients having non-elective surgery stayed on average slightly above the England comparator, at 5.4 days. The main areas where length of stay was higher was trauma and orthopaedics, at 8.9 days, compared to England average of 8.5 days and urology, 3.6 day stay compared to England average of 3.3 days. For patient having non-elective general surgery the length of stay was 3.6 days, which was less than the 4.2 day England average.
- Relative readmission rates provided to us did not necessarily reflect accurate information since the merger. However, we noted from the information available for elective surgery at Ealing Hospital trauma and orthopaedics was the one area which exceeded the England average, with a 75% chance of readmission. For non-elective surgery trauma and orthopaedics readmission rates were above the England average, and urology was also slightly above - at 58% and 9% respectively.

Surgery

Competent staff

- We reviewed a detailed training competency record for theatre staff, which included information with respect to each staff member, what they had completed and when.
- Staff told us they had the opportunity to identify and discuss their training and development needs during their performance review. We were told by staff they had been able to undertake appropriate training to meet their learning needs. This included attending external forums. For example a member of staff was funded to attend a forthcoming conference related to day surgery.
- Band five and six nurse who spoke with us in a focus group reported there was good support for professional development, with trust provision through the education learning and development department. Staff reported they had been encouraged and given opportunities to develop themselves. For example, a band six nurse had recently completed the tissue viability course and a leadership and management course.
- The arrangements for supporting and managing staff included one-to-one meetings, appraisals, coaching and mentoring. A newer member of theatre staff explained how they started their role with no prior experience and how they had been supported by a nominated line manager as well as having opportunities to work with various team leaders. They had completed competencies and had a six month review of their progress.
- Staff had access to a practice development lead in theatres.
- Appraisal rates were reported on the workforce and safer staffing performance indicators. For ward 7 North we saw a rate of 97% had been achieved in the year to date. In theatres the appraisal rate was 80% and on Brunel ward it was 97%.
- Information provided to us indicated there were 112 surgical staff in the surgical directorate, although these numbers were not site specific. Of these we noted there had been 11 staff who required revalidation up to this point in time and these had been completed.

Multidisciplinary working

- We attended the multidisciplinary team (MDT) on ward 7 South, which on weekdays, Monday to Thursday was attended by occupational and physiotherapists, the discharge co-ordinator and nurses. On a Friday doctors also attended the MDT meeting. We heard information, which demonstrated discussion of patient progress and decisions around discharge needs. Staff were observed working together to assess and plan on-going care and treatment in a timely way when people were due to be referred for other services or to be discharged. The meeting was quick and efficient and information from the meeting was communicated to staff on the ward and at subsequent shift changeover.
- Nurses told us that for patients who were described as 'long stayers' there was a separate MDT meeting on ward 7 North, which facilitated discussion of progress and rehabilitation needs and included family members too. The MDT meeting held on a Friday on ward 7 North was led by the care of the elderly consultant.
- Patient discharge arrangements were aimed to take place at a reasonable time of day. However staff on Brunel Ward reported day case patients were discharged as late as 11pm. This was said to be for a range of reasons but mainly because the individuals were later back from theatre and had not sufficiently recovered. We asked if there was any formal monitoring of the numbers of late discharges and were told there was not. Furthermore, we found the surgical care performance dashboard only collected data for patient discharges prior to 11am.
- Where patients required on-going care such as the interventions of a community nurse, referrals were made prior to discharge.
- Most patients who spoke with us were aware of the arrangements for their discharge, including when that was expected to be and if they needed to have any outpatient appointment or medicines.

Seven-day services

- There was provision of emergency theatres at all times, including out of hours. Surgical patients were seen daily by a member of the surgical team for the speciality or by the on-call person.
- Nurses reported having a limited service provided by radiology and for patient scans at weekends. They reported having access to pathology and pharmacy services on Saturday and Sunday mornings. On-call service was provided for pharmacy outside of these hours and there was access to backup medicines.
- There was a weekend physiotherapy rota for respiratory patients and a voluntary seven day occupational therapy service across all specialities within the

hospital. In addition, an emergency out of hours on-call service for patients with respiratory complications was available out of hours 365 days of the year operating from 16.30 to 8.30 am.

- We were provided with information with respect to surgical arrangements for out of hours (OOH) in the ENT service. A service level agreement was said to be in place for out of hours ENT cover provided by another hospital. The trust was said to be in negotiation with Ealing to take on full 24/7 cover at Ealing including on-call, surgery, and ward rounds. There was no urology week-end and OOH cover on site. However, the ward round was done by a senior SpR over the week-end.

Access to information

- We observed information needed to deliver effective care and treatment was available to ward and theatre staff. This included details of patient admissions, theatre schedules, patient records, risk assessments and guidance.
- Information to support the delivery of services was accessible on the trust intranet and also in paper copies in most areas.
- We noted in minutes of clinical governance meetings theatre safety bulletins were discussed, along with patient safety alerts.
- Referral information for community services, discharge, transfer and transition was shared appropriately and in a timely way.
- An electronic discharge summary was completed for each patient. Patient discharge information was communicated to GPs, with details of the surgery or treatment the patient had received. Care summaries were provided on discharge to ensure continuity of care within the community.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- A matron confirmed Mental Capacity Act (MCA) training as being an “essential” subject for staff to attend and the content included consent and Deprivation of Liberty Safeguards (DoLS). However, other staff were not sure if they had undertaken this training, but there was awareness within the nursing staff of the importance of completing relevant documentation with respect to DoLS. We tried to identify the uptake for MCA and DoLS training and when we looked at the electronic data base, we found whilst it was indicated as a mandatory subject, there were no training results available. Further investigation found the course stated it was not ‘enrollable’ at the time.
- Staff were aware of the differing consent forms and where an individual lacked capacity, consent form four was used. Best interest decisions were said to be made, where possible involving the relevant family, power of attorney or social worker. The consultant or registrar signed the consent form when such decisions were reached.
- We found,in our checks of patient records, evidence of consent forms for a range of surgical procedures. In addition we noted a patient had signed a consent form to indicate the sharing of information with the National Joint Register. Patients who were asked about consent reported having information provided to them so that they could make informed decisions.
- We saw evidence of MCA assessment documented.
- An audit of compliance with expected standards around consent was undertaken in July 2015. The sample of consent forms reviewed included 37 relating to patients on surgical wards at Ealing Hospital. Of these 70.3% had been signed by the surgeon performing the operation but 24.3% had not been signed. A further 2.7% were illegible and operation notes were not available in the remaining. Job title was stated in all consent forms reviewed. The benefits of having the surgery had been included in 97.2% and risks had been recorded in all forms reviewed. Responses from patients about consent presented favourable feedback in most of the questions asked. The lowest responses related to 25% of patients not having information about the type of anaesthetic they were to receive. An action plan had been developed from the findings and this included for example the provision of formal consent training.
- We found from our checks of patient records and it was confirmed by patients we spoke with there had been discussion about potential risks. One patient told us that in addition to having information about what would be done if there was a problem; they were also told what they were not consenting to.
- Mental capacity to consent to care or treatment was assessed during pre-admission or during their medical and nursing assessment, if admitted as an emergency. The outcome of such an assessment was documented in the individuals care record.

Surgery

Are surgery services caring?

Good

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

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

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

Compassionate care

- From our observation of staff interactions and a review of information within patient records we noted that nursing and medical staff understood and respected people's personal, cultural, social and religious needs. Relevant information was taken into account in addressing personal needs, such as diet and interpretation needs on wards.
- Staff reported to us that they would raise concerns about disrespectful, discriminatory or abusive behaviour or attitudes.
- We observed ward nursing staff, medical personnel and allied health professional ensuring people's privacy and dignity was respected as they went about their duties. This included addressing people in a respectful manner and by their preferred name; ensuring curtains were closed around bed areas and responding promptly to requests for assistance. Staff made every effort to respect patient confidentiality during ward rounds, handover at shift changes and in their handling of sensitive information, including patient records.
- We spoke with nine patients across the three ward areas, all of whom commented favourably on their experiences of using the surgical services. For example the responsiveness of staff, of feeling safe and cared for. A patient on ward 7 South told us the nurses were nice and friendly, polite and kind. They did add that they needed to check on patients more frequently and whilst responses to call bells had been better that day, it was less so the previous day. This patient informed us that the patient opposite them did not speak English as their first language and staff took a long time to respond to their request for assistance. We were told by this patient they would not recommend the hospital based on their experience.
- We observed nursing staff to be responsive to call bells whilst we were on the ward.
- A patient who had previously experienced the services of the hospital reflected on their time on ward 7 South. They told us they had a good experience thus far, everyone had been very friendly and "the doctors and nurses were very good." Staff had been respectful and attentive towards them.
- Two patients and the relative of one spoke with us on Brunel Ward and were very complimentary about their experience since arrival on the ward. One patient told us their expectations had been low but they had been "surprised by the level of kindness." We were told by another patient it had been excellent, as their relative had been able to accompany them to theatre to assist in communicating.
- One patient reported having had to wait for pain relief and wound dressings because nurses were busy on ward 7 South. They added that the delay was explained by nurses. Another patient on ward 7 North wanted to express how different their experience had been prior to admission, with three visits to the emergency department (ED) before they were finally admitted. They told us absence of notes from earlier attendance at the ED had contributed to staff not being aware of the severity of their condition. However, they told us their care had been very good since admission to the ward.
- We followed one patient from the ward through to the operating theatre and observed that staff interacted in a polite and caring manner towards the patient. All procedures were explained fully to the patient before carrying them out.
- Staff encouraged patients to be as independent as possible and reflected their level of independence in the nursing documentation. For example, if a person could mobilise freely or attend to their own hygiene needs. We observed that patients were able to get out of bed and sit in a chair or move about the ward areas, subject to

feeling well enough. We observed staff supporting patients with their mobilisation and being both supportive and encouraging in their approach towards them.

- Friends and Family Test (FFT) results for the period from March 2014 to February 2015 indicated an average response rate on ward 7 North of 27% and ward 7 South of 25%. There were at least two months on both wards where there had been no patient feedback via the Friends and Family system. We saw results of FFT on display and noted for example 89% of respondents on ward 7 North would recommend the hospital year to date.

Understanding and involvement of patients and those close to them

- A patient who spoke with us on ward 7 South reported a lack of information provision, both in the emergency department and since their arrival on the ward. At the time of our discussion they said they did not know what was happening. Another patient on this ward told us they had been kept informed and their next of kin had been involved in discussions.
- Staff recognised when patients needed additional support to help them understand and be involved in their care and treatment. For example, staff recognised and responded to the individual needs of a patient with a hearing impairment and made sure they took time to communicate clearly but also that their relative was able to be present at times when essential information needed to be communicated.
- We saw evidence and heard from patients that they had opportunities to discuss their health needs, concerns and preferences to inform their individualised care. However, the generic documentation used by nurses did not facilitate the inclusion of specific details related to choices and preferences.
- Most patients told us they had been given information to assist them to understand relevant treatment options, including benefits, risks and potential consequences. This included formal consent prior to surgery and informal agreement prior to interventions, such as taking blood.

Emotional support

- A review of patient care records demonstrated patients had their physical and psychological needs regularly assessed and addressed, including nutrition, hydration, pain relief, personal hygiene and anxiety. We saw progress notes written by nursing and members of the multidisciplinary team to reflect changes in needs.
- Staff understood the impact that a person's care, treatment or condition had on their wellbeing and on those close to them, both emotionally and socially. Regular checks of patient wellbeing were taken in the form of comfort rounds. Family and carers were encouraged to visit and be involved where possible in supporting their relative.
- There was access to expertise and additional advice and support from specialist nurses, learning disability and dementia lead nurses.

Are surgery services responsive?

Requires improvement

Referral to treatment times were not being met in a number of surgical specialties. Adjusted referral to treatment within 18 weeks was worse than the England average between the period of September 2014 and April 2015 for five surgical specialties. The referral to treatment for incomplete pathways in October 2015 was 93.2% which was above the 92% standard.

Theatres were not always effectively utilised and operating sessions started and finished later than planned, which impacted on patient discharges.

The hospital operational management team had oversight of the status of the hospital at any given time and bed availability was managed well.

The individual care needs of patients were fully considered and acted on by staff. Arrangements were provided to support people with disabilities and cognitive impairments, such as dementia, although there had been little focus on developing the surgical services to improve the environment for such patients receiving surgery. Translation services were available and staff had access to information and expertise to facilitate responsive communications.

Surgery

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

Service planning and delivery to meet the needs of local people

- Services had recently been reviewed and changed to address the emerging strategy of the trust. Gynaecology surgery had moved to Ealing Hospital and other services had moved to separate locations within the trust.
- There was access to pre-assessment clinics, which facilitated preparation and planning for surgery based on patient need and any identified risks.

Access and flow

- Access to surgical services was via GP referral subject to consultation review or via the emergency department (ED).
- Information related to referral to treatment (RTT) within 18 weeks was supplied for the trust and was not location specific. This indicated five surgical specialities not meeting the targets, including; general surgery (69.1%) RTT, trauma and orthopaedics, (83.4%), urology, (83.2%), ENT (82.8%) and oral surgery, (74%).
- There was provision for pre-admission assessment by designated nurses. The pre-assessment service was described as “very good” by one patient and that it was very thorough.
- With the exception of two patients we were not made aware of any problems in having access to initial assessment, diagnosis or urgent treatment. The service prioritised care and treatment for people with the most urgent needs and there was access to emergency theatre.
- There was an appointments system for outpatients and investigative procedures, of which one patient reported some degree of confusion and unnecessary cancellation due to poor communication. The latter had resulted in them having to contact the department directly to reorganise.
- Theatre utilisation was not always effectively achieved. Data was provided for Ealing Hospital, which indicated average utilisation of 70.7% across the period July to September 2015.
- Cancellation data provided to us indicated that, out of 277 listed operations in September 2015, 233 took place. There had been five cancellations for hospital reasons (1.8%), 39 for patient reasons, (14.1%), including nine patients who did not attend.
- Between January 2014 and March 2015 there had not been any patients who did not have their treatment within 28 days of a cancelled procedure at Ealing Hospital.
- Endoscopy staff reported there were insufficient endoscope stacks, with no back up for times of failure. In addition during the week, if a stack and flexiscope was required in theatres, a scheduled list in endoscopy would be delayed and or cancelled.
- We found theatre times did not always run to expected times and we noted that where delays were identified staff reported these on the Datix system.
- Multidisciplinary meetings included discussion of patient discharge arrangements. The discharge co-ordinators engaged with other staff at the ‘morning and lunch time bed capacity meetings so that information could be shared. We noted the performance scorecard for the surgical division indicated 9.8% of patient discharges happened before 11am in July 2015, with a year to date figure of 12.5%.
- Theatre staff told us they were made aware of the location of surgical “outliers” on other wards and the detail of ward location was made clear on the theatre list.

Meeting people’s individual needs

- Surgical services were accessible to all regardless of disabilities. Arrangements had been made to make facilities accessible with appropriate aids. Wards provided single sex accommodation and access to separate toilet and bathing facilities.
- The endoscopy department did not have the ability to segregate female and male patients in the area used for pre and post procedure care. To mitigate this staff were having to ensure that admissions were managed so that males came on one day and females on another.
- Multidisciplinary meetings took place specifically for long stay patients, during which progress was discussed along with rehabilitation needs. Arrangements for on-going care took account of individual needs of people being discharged with complex health and social care needs.

- Ward staff confirmed that they were able to make links with interpreters via telephone or if necessary face to face. However, staff working in endoscopy reported feeling frustrated as they had to arrange lists around the availability of interpreters. This was despite many staff being multi-lingual but not being permitted to interpret in line with the trust policy.
- Nursing staff confirmed there was access to information and expertise related to the provision of care to support people with a learning disability. We saw relevant information displayed on the notice board on ward 7 South to guide staff. A detailed resource file was available on Brunel Ward, which contained a range of communication tools and other guidance.
- We observed staff supporting individuals where they needed help with eating or drinking because of their frailties. A purple flower symbol was used to indicate where staff were required to support people to eat and drink.
- We noted there was a trust wide dementia strategy, which outlined the aims and objectives for improving inpatient and community patient care with respect to dementia services. However, we found that there had been little focus on developing the surgical services to take into account the needs of people who were living with dementia. With the exception of a side room on ward 7 North, we did not see any evidence that attention had been given to the environment to make it dementia friendly. We saw a 'forget-me-not' sign in use on ward 7 North but not elsewhere. In our discussion with staff they confirmed that apart from providing one to one support if necessary, and having links to the dementia lead nurse, there had not been any measures taken to improve this area.
- Nursing staff told us patients could be referred to the mental health nurse for psychiatric support.
- We noted there was a range of literature available for patients and visitors to access on wards. This included for example, safeguarding information, slips, trips and falls advice, information on neck of femur fractures.
- We observed that there was a range of cultural and medical related diets available to patients to choose from. For example; low fat, Kosher, Halal, Diabetic, Vegan and African or Caribbean main courses.

Learning from complaints and concerns

- Senior nurses who spoke with us in a focus group reported that the complaints department had not been merged across sites and was challenging. They indicated that this was because there were different approaches, and tracking was difficult, making it hard to get a grip across all three sites. They told us some aspects were being worked on and a common database was in development.
- Information was displayed in surgical areas with respect to raising a concern or complaint.
- We saw there was a formal process in place for recording complaints, the location and specialty, date received and outcome. This included if the matter was closed or not.
- We reviewed examples of final letters written to complainants, in which the trust acknowledged the matters raised and investigated and responded accordingly. The process reflected an open and transparent process.
- We saw that clinical governance meetings were used as an opportunity to discuss complaints, feedback from these and any required action. For example, the minutes of the urology clinical governance meeting held on 9 July 2015 included actions to be taken to address the provision of information related to possible post-surgical complications.

Are surgery services well-led?

Requires improvement

The surgical risk registers did not always identify the relevant hospital location where the risk presented. Timelines had not been assigned for resolution of risks in all cases.

Staff reported positively on their immediate line managers, their approachability and support and said they were valued and respected, but reported a disconnect between the locations and a lack of visibility of senior personnel.

The majority of staff did not have a full awareness of the broader vision and strategic aims of the surgical directorate or the trust itself. This reflected the lack of information they perceived in relation to future services at Ealing Hospital.

Senior leaders understood their roles and responsibilities and were aware of the impact the recent changes following the merger had on staff.

Surgery

Effective governance arrangements were in place to monitor, evaluate and report back to staff and upwards to the Trust Board.

The surgical directorates identified actual and potential risks at a service and patient level and had in place mechanisms to manage such risks and monitor progress.

Patients and staff were encouraged to contribute to the running of the service, by feeding back on their experiences.

Vision and strategy for this service

- There was an absence of overall awareness of a vision for surgery. There had been workshops around a divisional strategy but there was not a vision and strategy document in place at the time of our inspection. Information about it was piecemeal.
- There was a mixed response from clinical staff, including those in more senior positions as to their understanding of the trusts overall vision and aims. We were told by a member of nursing staff the trust vision was about high quality patient care, providing a good service, a good experience and about looking after staff. A junior doctor who spoke with us was not aware of the trust values and aims.
- A member of theatre staff told us the aims and objectives had not been shared widely. However, there was awareness in nursing and theatre staff of the move of some surgical services. It was evident from staff they had concerns about the future of the location and they commented on the lack of detailed information about the direction of travel in relation to services and the hospital itself.
- We spoke with the divisional leads for the surgical directorate about the service strategy. We were informed there had been several workshops around the development of a strategy, which had included post-merger meetings with surgeons and anaesthetists to discuss where services should be. Most of the aims were said to have been achieved, such as moving services within the separate locations. For example, the majority of gynaecology services had moved to Ealing Hospital in order to strengthen their services.
- We reviewed several copies of minutes for the theatre users committee meetings. These contained a regular agenda item related to the surgical strategy and progress on this.

Governance, risk management and quality measurement

- The surgical directorate was overseen by a divisional clinical director, general manager and head of nursing. There were two divisional governance co-ordinators and one designated service improvement lead. Staff holding these roles were clear about their responsibilities and understood what they were accountable for.
- The performance management data collected for surgical services included a range of areas, such as patient safety and the patient's experience. Performance indicators were reported monthly and were reviewed as part of the governance processes.
- Senior nurses who spoke with us in a focus group meeting reported since the appointment of the new CEO changes in risk management and governance structures had given them more assurances. For example, there was a more structured reporting via dashboards of key performance indicators (KPIs).
- Senior nurses told us they did not necessarily attend the monthly clinical governance meeting but they attended sister's forums, where they received information from matrons.
- Management of the risk register appeared disjointed. A matron informed us the risk register was reviewed at the clinical governance meeting, which mainly took place on other hospital locations. Because of this they had to prioritise if they went to the meetings or not. They were not aware what risks were on the register relating to Ealing and hence the risk register did not necessarily contain all the risks at Ealing.
- We reviewed the surgical risk register and found this identified risk by specialty, type and attached a risk rating. A responsible lead was assigned and the risk management plan had been summarised and progress noted. However, it was not always clear which site the risks related to and timelines had not always been assigned to risks for resolution

Leadership of service

- During our discussion with a number of consultants they told us the board level management were not visible and unsupportive, with the exception of the Medical Director. They added decisions were made and policies enforced without the backing of the teams, for example,

they had been told to conduct bi-weekly M&M meetings, but did not have the time to facilitate them. Further, they did not have protected handover time, despite presenting evidence showing they should.

- We observed staff working well together in all areas visited. There was enthusiasm and willingness to provide high standards of care. These observations supported feedback we had received from senior nurses, who reported an 'all hands on deck' approach when needed. They told us there was a good consultant and matron presence on site, so issues were usually resolved.
- Staff working on wards and in theatres reported their immediate leaders as being knowledgeable and supportive. When band six and band seven nurses took charge they were reported by one nurse to be quite well led.
- Matrons were described as being polite and caring towards patients and that they were very approachable. There was an awareness and understanding of the problems experienced by staff on the 'shop floor'. A matron reported to us considerable changes in management since the merger, both positive and negative.
- However, most managers were based at Northwick Park location. Matrons reported feeling supported and having regular communications, as well as being able to attend meetings. The latter was said to be difficult due to travel but there were video links to facilitate engagement.
- Band five and six nurses who spoke with us at a focus group reported a sense of loss of senior nurse leadership at a time when they needed support and that leaders were often at Northwick Park Hospital (NPH). They also reported a lack of visible management in the hospital since merger.
- Senior nurses who spoke with us in a focus group indicated that it was difficult to sustain a presence across three sites, as well as community. We were told it was difficult to manage staff expectation of their visibility across sites.
- Site managers and practitioners had video conferencing and we were able to observe this in action within a bed meeting and capacity review. On the Ealing Hospital site we were told there was one site manager to deal with lots of issues and problems on site. This made it difficult at times and an example was cited where there had been a bomb scare six weeks earlier and there were no other senior managers on site.
- The chief executive and lead nurse were said to have been visible on the ward and in theatres. Staff told us they also received weekly reports, which had lots of detail therein.

Culture within the service

- Nursing staff told us they were respected and valued by their colleagues, were able to share ideas and suggestions and they were listened to. One nurse told us the manager had called them to give a letter of commendation from a patient.
- The culture was described by a matron as being friendly, like a family, with mutual help to one another. They did say there was a degree of low morale as there were worries about the future of surgery provision at the location.
- We were told by nursing staff the culture enabled them to speak up and they had confidence things would be dealt with and that confidentiality was also respected. A member of nursing staff reported a fair approach to training and progression, which was anti-discriminatory.
- Theatre staff reported being able to work well with consultants and that they were approachable and respectful towards them when they asked questions.
- Safety and wellbeing of staff was reported by staff to be considered by managers. There was a focus on safe staffing levels and awareness of the impact of working over and above expected hours.
- Sickness absence was monitored and there were policies in place to address capability.

Public engagement

- We asked nursing staff if there was any public engagement taking place to gather their views and help shape the services. There was no awareness of such engagement.
- We noted feedback from patients and their families was gathered through the Friends and Family Test. In addition the wards had 'you said, we did' boards and information was recorded on these. For example, noisy at night was mentioned and in particular the noise from bin lids closing. The response was that new soft closure bins had been ordered.

Surgery

Staff engagement

- Staff in theatres reported poor staff survey engagement and of feeling they may be targeted if they wrote anything negative. We saw an action plan had been developed from the results of the most recent staff survey. The actions related to mandatory training, appraisals and bullying.
- The staff survey results for 20 March 2015 were reviewed by us. We noted 69% of respondents on ward 7 South reported to agree they perceived themselves to be part of a strong team with a good team spirit and 15% strongly agreed with this question. 38% and 15% respectively either agreed or strongly agreed with the question: My opinion matters in how the ward/ department is run. However, 15% strongly disagreed with the latter question. There were no results reported for ward 7 North or Brunel.
- Staff did not feel actively engaged in the planning and delivery of services and in shaping the culture or the future of services.
- Staff understood the value of raising concerns and said these were generally acknowledged and addressed.

Innovation, improvement and sustainability

- We asked staff to tell us about any innovations or aspects of their work which should be celebrated. Staff could not describe any examples of anything extraordinary happening or any particular projects or activities. They did tell us in theatres how they celebrated the fact they were heading in the right direction, that morale was much better than it had been two years ago.
- The service had received an excellence award for quality improvement in reducing time to surgery for patients with fractured neck of femur. The outcomes showed a reduction in mortality from 8.5% to 4% over a year and time to surgery from 48% to 93% within 36 hours of admission.
- Nursing staff had been encouraged and supported to continuously learn through such courses as mentorship and leadership programmes. We were not given any examples of how such learning had contributed to improvement or innovation. Despite this staff were very aware of the need to focus on the delivery of quality care and recognised how information provided from performance results contributed to enhancing patient care outcomes.

Critical care

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

Information about the service

Critical care at Ealing Hospital (EH) is delivered within a nine-bedded unit separated into individual patient rooms which is located on the first floor of the hospital. The unit could accommodate a maximum of nine level three patients at any time, although a combination of level two and level three patients was usual. Level three patients require advanced respiratory support alone or basic respiratory support along with support of at least two organ systems. Level two patients require detailed observations or interventions and require higher levels of care due to a single failing organ system or postoperative care. There were 225 admissions to the critical care unit between January and July 2015.

Most patients (76%) are admitted to critical care after becoming unwell on the hospital wards or via the emergency department due to complex medical needs. Some patients (24%) are admitted following elective or emergency surgery. A critical care outreach team is available to assess deteriorating patients on the wards and to follow up patients who have been stepped down from critical care

We visited the critical care unit over the course of two announced inspection days. During our inspection we spoke with 22 members of staff including doctors, nurses, allied health professionals and ancillary staff. We also spoke with the critical care leadership team, three patients and four relatives. We checked seven patient records and many pieces of equipment.

Summary of findings

Overall the critical care at EH was good. Patients were cared for by a safe number of competent staff who used evidence-based practice to achieve good outcomes. Staff had good access to patient information and current best practice guidelines as well as up to date research articles. Patient safety thermometer results were good and there was a proactive incident reporting culture. We saw evidence that incidents were investigated appropriately, with learning points disseminated to unit staff,. hHowever, there was limited shared learning relating to incidents. The vision for the service focused on an improvement in quality and safety through investment in staff training and development. We saw some evidence of innovation such as the development of the high flow oxygen service.

The critical care service was caring and patient privacy and dignity was maintained at all times. Staff knowledge and implementation of safeguarding was good and we saw evidence that regular patient risk assessments took place. Patients' pain was frequently assessed and well managed by staff who ensured patient comfort at all times.

Multidisciplinary working was embedded on the unit, particularly during the weekly meeting.However there were insufficient number of pharmacy and dietetic staff to meet best practice recommendations. Senior and junior staff's knowledge of consent and Deprivation of Liberty Safeguards was variable.

Critical care

There was a capacity shortfall on the unit and we saw difficulties with patient flow through critical care. This was not on the department or trust risk register and there was no strategy in place for addressing the capacity shortfall. There were higher occurrences of unit-acquired methicillin-resistant staphylococcus aureusis and blood infections than on other similar units.

Staff perceived that there was a poor relationship with trust senior management. In their opinion the critical care service was not valued within the organisation. Senior staff expressed concerns at the lack of understanding relating to critical care and hesitation at raising problems with trust management due to potential repercussions.

Are critical care services safe?

Good

Safety within the critical care unit was good and people were protected from avoidable harm and abuse. There were thorough patient risk assessments completed at suitable intervals and staff responded appropriately to changes in risks. Patient safety thermometer results were good. Staff demonstrated appropriate knowledge and understanding of safeguarding principles, and we observed embedded systems to keep people safe from abuse.

Staff understood what types of situations needed to be reported as incidents and were proactive in doing this. Investigations completed as a result of these reports were suitably thorough and involved all relevant staff members. Lessons were learned and communicated across the critical care unit to prevent the same incident occurring again. Staff understood and adhered to duty of candour principles.

Patients were cared for on a clean unit where staff followed infection prevention and control principles, including the correct use of personal protective equipment, however there were more cases of methicillin-resistant staphylococcus aureusis and unit-acquired blood infections than on other similar units. Medicines were prescribed, stored and administered correctly, however pharmacy provision on the unit was not in line with recommended levels.

Patients were cared for by safe numbers of nursing staff; however staff feedback and our observations suggested an additional supernumerary member of staff to assist with patient care tasks, and to allow staff adequate breaks, would be beneficial due to the layout of the unit limiting staff working together. There was suitable provision of medical staff to care for patients on the unit but all the doctors left the ward to attend the weekly multidisciplinary meeting. This left the unit without a doctor immediately available, which does not follow recommended practice. Uptake of certain aspects of mandatory training was poor.

Incidents

- Incidents were reported on electronic forms which were accessed by all trust staff on any trust computer. We saw evidence of staff reporting incidents during our

inspection. There were no serious incidents or never events relating to the critical care unit between April and September 2015. Serious incidents known as 'Never Events' are largely preventable patient safety incidents which should not occur if the available preventative measures had been implemented.

- Staff on the critical care unit were aware of the incident reporting process and were able to give a range of incident examples which would trigger an incident report, including near-miss scenarios. Staff told us incidents were "almost always reported on the same day".
- We saw evidence of root cause analysis (RCA) taking place when incidents had occurred and these RCAs demonstrated thorough investigations which involved all relevant members of staff. Staff had access to completed RCAs relating to incidents which had occurred on the unit as these were stored in a folder on the ward. Learning points from incidents were passed on to ward staff during staff meetings, handovers or by email.
- Staff told us they usually received feedback for incidents they had reported although there were some occasions they had to request information regarding the outcome. Staff confirmed general incident feedback occurred during handovers and staff meetings and they said this was an effective way to communicate the learning points raised.
- Regular multidisciplinary clinical governance meetings were held; they discussed themes of incidents which had occurred on the unit, action points identified and reviewed actions from previous incidents.
- They held morbidity and mortality meetings which reviewed the clinical management of any patients who had died on the unit and analysed whether the care received by the patient was correct, appropriate and suitably optimised. These governance processes were in line with recommendations from the 'Faculty of Intensive Care Medicine Core Standards for Intensive Care Units'.
- Senior critical care staff demonstrated a thorough understanding of principles relating to duty of candour requirements and told us the responsibility for this would lie with the lead consultant or lead nurse. Staff across all levels described the need to be open and honest about mistakes and to apologise when incidents occurred.
- We saw evidence of letters to patients and their families demonstrating adherence to duty of candour principles when incidents had occurred. These letters contained apologies and provided thorough explanations of the incidents and learning points which had been raised as a result of this.

Safety Thermometer

- The NHS Safety Thermometer is a national tool used for measuring, monitoring and analysing common causes of harm to patients, such as new pressure ulcers, catheter and urinary tract infections (CUTI and UTIs), falls with harm to patients over 70 and Venous Thromboembolism (VTE) incidence. Safety thermometer and safe staffing details were displayed on a noticeboard in the critical care unit. Safety thermometer data detailed below refers to the period October 2015 to September 2015.
- There were two unit acquired pressure ulcers reported on the critical care unit. During our inspection, we saw patients' risk of developing a pressure ulcer wasere assessed using the Waterlow pressure ulcer prevention score. A staff nurse was identified as the tissue viability link nurse who worked closely with the hospital tissue viability team to ensure best practice was followed in critical care.
- Catheter care bundles were used throughout critical care and there had been no instances of CUTIs during the data period specified.
- There were no falls with harm to patients in intensive care during the reporting period. We saw evidence of completed falls risk assessments and timely referrals to physiotherapists were made when concerns arose.
- VTE assessments were recorded on the daily care chart and completed each day. There were no new VTEs within critical care during the reporting period. Hospital audit data demonstrated 100% of patients were assessed for VTE risk at appropriate intervals during their admission to critical care which was in line with National Institute for Health and Care Excellence (NICE) quality standards.

Mandatory training

- General mandatory training (such as fire safety) was delivered as part of the generic trust induction process. Refresher courses and role specific mandatory training needed to be booked separately and was the responsibility of each individual to organise.
- Staff were able to complete their mandatory training during working hours, with time off the ward allocated in order to complete this. Most mandatory training was delivered via face to face learning but some modules, such as information governance, were completed on e-learning systems. Staff told us there were not enough mandatory training sessions held so sessions were often fully booked and it could be difficult to tie in training with days off the ward for training.
- Mandatory training rates were generally low with some important topics such as infection control (72.88%), information governance (58.33%) and medicines management (26.79%) particularly low.
- Senior staff told us the trust target uptake for each mandatory training topic was different and this sometimes led to confusion when assessing the performance of the unit. They identified certain mandatory training topics they wished to address as a matter of urgency, for example pressure ulcer prevention and management (39.29% completed).

Cleanliness, infection control and hygiene

- There was a member of housekeeping staff who provided dedicated support to the critical care unit between 7am and 3pm on a daily basis. Further housekeeping support was provided between 3pm and 7pm. Outside of these times, housekeeping services were available via a bleep system.
- Nursing staff were responsible for cleaning all medical equipment which was in use such as ventilators, any equipment which had been used with a patient such as a commode or pat slide, and any spillage of bodily fluids. All other areas of the ward were the responsibility of the ward housekeeper.
- Housekeeping staff used colour coded cleaning equipment to limit the risk of cross contamination between clinical areas, for example yellow cleaning equipment was used in isolation or barrier nurses areas.
- The critical care unit was clean throughout although we noted a significant coating of dust on several bedside fans and some dust on high level surfaces, such as on the top of the bedside patient monitors.
- Waterproof mattress covers were intact and mattresses were free from stains. We noted all fresh bed linen and blankets were free from stains and holes. We observed nursing staff disposing of used linen correctly into laundry bags; using separate red bags for linen used with barrier nursed patients.
- Due to the layout of the ward, all patients were nursed in individual rooms even if they did not require barrier nursing. Where patients did require barrier nursing, we saw warning signs in place on the door to the patient's room to alert staff personal protective equipment (PPE) such as gloves and aprons should be worn.
- None of the patient rooms had a decontamination lobby which was not in line with HBN0402 building note recommendations for accommodating barrier nursed patients. Two patient rooms had negative pressure capabilities which meant they could prevent airborne infective particles from spreading outside the patient room.
- Alcohol gel was available at the entrance to the unit and there was a sign reminding staff and visitors to clean their hands when entering.
- There were hand washing facilities within each room and a full complement of basic PPE such as aprons and various size gloves available at the entrance to the room. Alcohol gel was also available at the entrance to each room and at the patient bedside.
- We observed staff members adhered to the 'bare below the elbows' policy and wore PPE appropriately to complete patient tasks. We noted correct removal and disposal of PPE and adherence to hand hygiene protocols, including washing hands with soap and water or use of alcohol gel.
- Data from the 'Intensive Care National Audit and Research Centre' (©ICNARC) database demonstrated a consistently higher occurrence of unit-acquired methicillin-resistant staphylococcus aureusis (MRSA) between January and June 2015 than on other similar units.
- ICNARC data showed there was generally a lower incidence of C. Difficile than on other similar units. Hospital audit data demonstrated there were no cases of hospital acquired on critical care C. Difficile between April and July 2015.
- Unit-acquired blood infections occurred consistently more frequently on the critical care unit than on other similar units between January and June 2015 according to ICNARC data. Senior critical care staff told us they had

implemented an improvement action plan which included the allocation of a lead nurse in intravenous (IV) line care, reviews of the central venous catheter (CVC) packs and review of aseptic non-touch technique training. According to staff, the trend of unit-acquired blood infections was improving as a result of these changes. Compliance with CVC care bundles was reported as 96% between April and June 2015 according to data from the North West London Critical Care Network. This was in line with the performance of other units in the local area.

Environment and equipment

- Entry to the unit was obtained via a staff controlled video buzzer entry system which meant staff knew who wanted to come onto the unit before granting them entry. We saw staff checking a visitor's identity against a list of authorised people to see a specific patient who had complex social issues and was only receiving certain visitors.
- There were five patient rooms within the main ward area which were usually used for level three patients and four additional rooms in the theatre recovery area which were mainly used for level two patients. Most patient rooms were not large enough to comply with HBN0402 guidelines..
- Pendant patient monitoring equipment was present in each room which meant staff could access all sides of the bedside. Staff told us the monitors needed replacing soon due to "old age" and this was logged on the risk register for the unit. New monitors had been chosen and staff told us the new system would allow remote patient monitoring, such as if a patient was taken for a CT scan.Staff on the unit would be able to monitor the patient's vital signs remotely in addition to the staff member escorting the patient.
- Clinical waste and general waste bins were available within each patient room and also within the ward area. All bins were soft closing and none were seen to be overfull.
- Needle sharps bins were located in each patient room as well as within the medicines preparation area. All sharps bins we checked were labelled correctly and none were seen to be overfull.
- An arterial blood gas analyser was available on the ward and staff told us this machine was calibrated at regular intervals. The machine was seen to be clean throughout our inspection.
- There was a resuscitation trolley available within the main ward area and also within the theatres recovery area. These trolleys were sealed with a plastic lock and we noted weekly checks were completed and documented. There were no gaps in the checking documentation we observed.
- Consumables within the unit were kept in storage cupboards containing labelled shelving and drawers so staff could quickly locate the items they were looking for. All consumables we inspected were seen to be in date. Stocking up the storage area was the responsibility of the health care assistants and staff told us there were no issues relating to the availability of items.
- The trust sub-contracts to a specialist contractor for all its medical equipment maintenance and to manage safety testing and day to day functioning issues. Most equipment was replaced via a 5five year replacement programme and funds for replacing capital equipment had to be obtained via business case submission. Electrical equipment was labelled as having been portable appliance tested (PAT) and had a date for review in place.
- Staff received specific training on some items of medical equipment. For example we observed nursing staff receiving training on the new digital storage system for medicines. Additional training records demonstrated other training on certain items such as the arterial blood gas analyser.

Medicines

- There was a 0.5 whole time equivalent (WTE) critical care pharmacist dedicated to the unit between 9am and 12:30pm Monday to Friday, supported by a pharmacy technician for two hours per week. The Intensive Care Society states a 0.9WTE pharmacist would be required for the number of beds on the critical care unit and so the current provision did not meet recommendations.
- The pharmacist was responsible for checking patient prescriptions for interactions, allergies and correct prescribing. The pharmacist also ensured adequate stock and appropriate storage of medicines on the unit,
- Medicines were prescribed on paper-based medicines administration charts which contained details of patient allergies, including the reaction caused by the medicine. Charts we reviewed were legiblye and details of the

medicines prescribed were correctly filled in, including dose and route of medicine administration. Prescriptions showed evidence of review by the ward pharmacist.

- We noted antibiotics were prescribed in line with best practice recommendations and trust guidance was available on the intranet. Additional assistance could be sought from the British National Formulary or from microbiology support.
- Medicines charts which were in use at the patients' bedside had been fully completed, including signatures when medicines were given or reasons for delay and omissions of medicines.
- Medicines stored in critical care were kept in an electronic storage unit which were accessed via a username and fingerprint log in. Staff had their own individual log in details to access medicines and had received specific training for this equipment. Agency staff were allocated a log in for this which lasted for a one week period.
- Some medicines were stored within a lockable medicines fridge. We noted temperature checks were recorded on a daily basis and there were no gaps in these checks on the records we reviewed.
- We observed nursing staff administering oral and intra-venous medicines while following correct procedures, including checking the medicine with another member of staff and the patient's identity.
- Controlled drugs (CDs) were stored in a separate lockable cupboard and required two nurses to be present for these medicines to be prepared and administered to patients. The keys to the CD cupboard were held by the nurse in charge during each shift and staff could access the keys by locating this member of staff on the ward or by bleep.
- We observed nurses on the critical care unit administering CDs following correct procedure, including two members of staff present to access the cupboard and double checking of the medicine and patient prior to administering the medicine.
- The contents of the CD cupboard were checked on a daily basis by two members of staff; usually the nurse in charge and another registered nurse. The contents of the cupboard were checked alongside the CD book and we noted accurate entries within the book, including two staff signatures for all medicines taken from the cupboard.
- Oxygen canisters were available on the ward within each patient bed space and within an oxygen storage area. All oxygen we reviewed was seen to be in date and all canisters were correctly stored in appropriate racks. We noted an empty oxygen cylinder in a patient room which had not been replaced. Staff rectified this issue immediately when we informed them of our findings.

Records

- Patient documentation was recorded on paper-based forms on the critical care unit. Daily care charts were used by nursing staff to record patient observations and activities, such as washes and repositioning. The daily care record also documented which lines the patient had in place and various assessments, such as the patient's conscious level and VTE risk. Patient records we reviewed demonstrated full documentation of care bundle compliance and were readily accessible to staff but stored in a way which would limit access to patients' relatives and visitors.
- Nursing notes were recorded on specific forms and kept in a special folder at the patient bedside. Nursing notes contained holistic information about the patient's day, such as whether any family members visited, as well as any significant medical occurrences. Entries were legible and most were were signed, with the staff member's name printed below.
- Entries from the critical care medical team and any visiting medical teams were documented in the patient's medical notes, which were also stored at the patient's bedside. There were loose sheets of documentation within the medical notes of some patients on the unit which could be easily lost if the notes were moved. Most entries by the medical team were legible and had been signed by the relevant professional.

Safeguarding

- A trust safeguarding policy was in place and accessible to all staff on any trust computer. Ward nursing and medical staff knew how to access this policy and could identify who to contact if a safeguarding referral was needed.
- Safeguarding adults level two training had been completed by 84.75% and safeguarding children level two training had been completed by 72.88% of critical care staff.

- We observed discussion of a safeguarding referral during the weekly multidisciplinary meeting. Clear reasons for the referral were identified and the action of making the referral was designated to a member of staff who was asked to feedback to the team once this had been completed. Staff members involved in this discussion were familiar with the processes and principles relating to safeguarding.

Assessing and responding to patient risk

- The Waterlow pressure ulcer prevention score was used to assess patients' risk of developing pressure ulcers during their admission. Staff described how to calculate this score and we saw evidence it was calculated at appropriate intervals. Staff told us special pressure relieving mattresses were used in critical care and special gel seat pads could be ordered if needed. We noted that pressure ulcer prevention and management training had been completed by only 39.29% of staff.
- Falls risk assessments were completed for mobile patients or confused patients who may try to mobilise independently. Staff told us physiotherapists would have early involvement with these patients and put in place measures to reduce the risk of patient falls such as using socks with underfoot grips to limit the likelihood of slipping.
- According to trust policy, the Confusion Assessment Method for the ITU (CAM-ITU) was used to assess whether patients were delirious whilest on the unit. This practice was in line with current best practice guidance from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. We observed this assessment had been completed with appropriate patients on ITU.
- Risk of VTE was assessed during the admission clerking for new critical care patients and on a daily basis after this. All patient charts we reviewed had completed VTE assessments and hospital audit data consistently showed 100% compliance. We saw mechanical and pharmacological measures in place to reduce the risk of VTE.
- Throughout the hospital, a National Early Warning Score (NEWS) was calculated whenever the patient's observations were taken which was in line with guidance from the Royal College of Physicians. The purpose of NEWS was to enable early identification of patient deterioration, as indicated by their observations. Patients scoring five or above were referred to the critical care outreach team for review and consideration of transition to critical care.
- The critical care outreach team was available 24 hours per day, seven days per week. Between January and September 2015, there was an average of 113 referrals made to the outreach team every month for patients scoring seven or more on the NEWS. This demonstrated an increase of 71% since 2013. Staff told us audit data showed there was a clear increase in calls to the outreach service when maximum capacity on the critical care unit was reached.
- The critical care outreach team were also responsible for following up patients who had been discharged from critical care to the wards within the previous 48 hours.
- Data from the ICNARC database demonstrated there were more in-hospital cardiopulmonary resuscitation (CPR) admissions to the critical care unit between January and June 2015 than in other similar units.

Nursing staffing

- Nursing staff worked in shifts from 8am to 8:30pm and overnight from 8pm to 8:30am. Handovers were completed at 8am and 8pm each day and comprised of a general overview of all patients on the unit from the shift leader before nurses received specific bedside handovers for their allocated patient/s. This ensured patients were cared for by safe levels of staff even during shift changeover times.
- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units states that all ventilated patients (level three) are required to have a registered nurse to patient ratio of a minimum of 1:1 to deliver direct care, and for level two patients a ratio of 1:2. The critical care unit used an acuity tool to assess the required staffing levels. Safe staffing data provided by the hospital demonstrated staffing levels of registered nurses was 98-103% of the planned levels between April and July 2015.
- There was a ward matron who was responsible for overseeing the critical care unit as a whole and a band seven shift leader who managed the day to day running of the unit. Both of these staff members were supernumerary, as recommended by the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.

- The remaining staff were allocated to patients and were a combination of band five and band six nurses. Senior staff told us they tried to ensure a good skill mix during each shift so there was sufficient support in place for less experienced staff members.
- At times it was necessary for patients to be cared for within the theatres recovery area when the unit had reached maximum capacity. When this occurred critical care nurses were allocated to these patients as if they were patients on the main critical care unit, adhering to the safe staffing recommendations.
- There was usually one member of staff who was designated as the 'runner'; they were not allocated to a patient and were available to support staff breaks, patient care tasks requiring more than one person and fetch equipment.
- Staff described the difficulties the critical care environment caused due to the single patient room layout and usually only having one 'runner' on shift. Staff told us they sometimes had difficulties fitting lunch breaks into their day and often had to wait for a long time to be able to test a patient's blood gas or get equipment as they had to wait for the 'runner' to be available to watch their patient (especially if caring for a level three patient).
- Staff told us the layout and staffing levels also made it difficult to get enough staff to turn patients, despite using the health care assistant and nurse in charge to assist with this. We observed one member of staff waiting to test a patient's arterial blood sample for over nine minutes because no other member of staff was available to supervise the patient while the allocated nurse did the blood test.
- The critical care outreach team was staffed by band seven nurses and the team had recently increased its support to provide a 24 hour, seven days per week service. Where gaps appeared on the rota due to the increased service provision, senior band six critical care nurses were used to fill these gaps after receiving outreach training. Agency nurses were used to backfill the shifts left vacant by the redeployed staff.
- At the time of our inspection, there were ten whole time equivalent (WTE) band five and two WTE vacancies on the critical care unit. A recently approved business case meant there were also four new WTE band seven vacancies within the critical care outreach team which were being advertised at the time of our inspection.
- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends no more than 20% agency staff usage per shift. Documentation we reviewed demonstrated use of agency staff within critical care was compliant with this standard.

Medical staffing

- There were five critical care consultants who provided cover for the unit. The consultant on duty covered the critical care unit for seven days at a time; working approximately 8am to 8pm, completing twice daily ward rounds and providing on call support for the overnight staff. The provision of consultants on critical care was compliant with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- Four associate specialist doctors supported the work of the consultant on duty, with two working during the day shift and one overnight. The associate specialist doctors were senior registrar levels doctors who were not currently employed under training programme. All associate specialist doctors had advanced airway skills.
- There was additional support for the consultant on duty provided by a staff grade doctor on the daytime shift.
- Two medical handovers took place each day where the staff coming on duty received information about the patients on the unit from staff finishing their shift. This information contained all relevant medical information as well as plans for the following days.
- When critical care was at maximum capacity and patients were cared for within theatres recovery, the critical care consultant reviewed these patients during twice daily ward rounds as per best practice recommendations.
- We noted all doctors left the critical care unit to attend the weekly multidisciplinary meeting, leaving no doctor immediately available on the unit. Staff told us this had been risk assessed as acceptable as all doctors were available via a bleep, were not geographically far from the unit and doctors were available within theatres, adjacent to critical care should an emergency arise. The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units advises critical care units must have immediate access to a practitioner with advanced airway skills which iswas not adhered to in this circumstance.

Major incident awareness and training

Critical care

- A copy of the hospital's major incident plan was available in paper format on the ward and on the intranet via any trust computer. The plan highlighted the expectations of staff within different areas of the hospital and identified that critical care should expect to receive additional patients in the event of an emergency which may mean sourcing additional staff who are off duty or on leave if able.
- Staff were aware of the major incident plan, however staff we spoke with admitted they had not personally reviewed the document. They told us they would be guided by senior staff on the unit in the event of a major incident being declared.
- Generator testing was completed on a weekly basis throughout the hospital and staff described how the critical care unit would receive a priority power supply due to the acuity and complex mechanical requirements of patients on the unit.

Are critical care services effective?

Good

Care provided on the critical care unit was effective and patients achieved good outcomes, due to evidence-based interventions provided by competent nursing and medical staff. The unit contributed to national and local quality databases which meant their outcomes were benchmarked against other units. Patient mortality was better than other similar units nationally and there were fewer early admission deaths. Patient pain was regularly assessed and well managed.

Staff had good access to information, including data relating specifically to individual patients and also best practice guidance and research. Multidisciplinary team (MDT) working was embedded and the weekly MDT meeting worked well with involvement from a range of professions. Seven day services across the MDT were not fully optimised and there was less than the recommended provision of dietetic support, however nutrition and hydration was carefully monitored by nursing staff.

Staff demonstrated good levels of knowledge regarding the Mental Capacity Act. However understanding of consent principles and the Deprivation of Liberty Safeguards was extremely variable, including amongst senior staff.

Evidence-based care and treatment

- Clinical policies and procedures specific to the critical care unit were available on the intranet and some printed copies were available for reference on the ward. Additional trust-wide policies were also available on the intranet. Policies we reviewed were seen to have been recently updated.
- An evidence-based ward round template was developed and used by some consultants responsible for critical care. This template ensured a logical and thorough approach to patient assessment during the ward round.
- The critical care unit used evidence-based protective lung ventilation with patients where appropriate and hospital audit data demonstrated 88% compliance with this practice.
- A ventilator-associated pneumonia (VAP) care bundle was in use to reduce the risk of infection associated with intubation and data from the North West London Critical Care Network between April and June 2015 demonstrated 100% compliance with this, which was in line with other units in the local area.
- All patients receiving mechanical ventilation on the ward had end tidal carbon dioxide monitoring built into their ventilator settings. This was in line with evidence-based recommendations from the Intensive Care Society.
- A central venous catheter (CVC) care bundle was used for the insertion and ongoing care of CVCs on the unit. Data from the North West London Critical Care Network showed service compliance with CVC bundles was 96% between April and June 2015, which was in line with other units in the critical care network.
- The Visual Infusion Phlebitis (VIP) score was used on the critical care unit to monitor the wellbeing of patient IV lines, this was in line with best practice guidance. We saw this documented in patient notes where appropriate.
- An evidence-based sepsis care bundle was in use in critical care and would be instigated on the hospital wards by the critical care outreach team if appropriate.
- Patients with catheters received care based upon an evidence-based care bundle specifically designed to reduce the risk of catheter related urinary tract infections. We observed use of this care bundle with all patients who had a catheter in place during our inspection.

- Faculty of Intensive Care Medicine Core Standards for Intensive Care Units advise all patients should be reviewed by an ITU consultant within 12 hours of admission to ITU. Staff told us all patients admitted to the unit would be reviewed by the ITU registrar or consultant prior to admission to the unit but time to review by a consultant after admission was not formally audited.

Pain relief

- All patients on critical care had their pain assessed on an hourly basis when their routine observations were being completed. We saw evidence of this documented on the daily care charts, other than when patients were asleep.
- Patients who were able to communicate their pain level were asked to score their pain on a given scale and were offered additional analgesia if appropriate. We observed documentation showing this in patient records.
- The Face, Legs, Activity, Cry, Consolability (FLACC) scale was used to assess pain in patients who were unable to communicate their pain. This scale used assessment of the patients' physical movements and responses to determine the level of the patient's pain. We saw this appropriately in use for unconscious patients on the critical care unit. Staff told us they also used the FLACC scale with patients with a learning disability who might not be able to communicate their pain level.
- Patients received pain relief via oral or intra-venous medicines including patient controlled analgesia (PCA) and patient feedback suggested pain was well managed on the critical care unit.

Nutrition and hydration

- There was 0.4WTE dietetic provision for the critical care unit, which was insufficient to comply with recommendations from the British Dietetic Associate and the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. The cover was provided by a band seven or band eight critical care trained dietician from Monday to Friday. Over the weekend, nutritional support was instigated by nursing staff if required.
- Patients who were able to eat were offered a choice of food from the hospital menu three times per day. The menu offered choices for people with specific dietary or cultural requirements, such as gluten free, vegetarian and halal meat options. Special meals were made available for patients who required certain textures of food, for example pureed food or soft options.
- We saw evidence that patients' food intake was monitored by nursing staff and this was recorded in the patients' daily care record. Staff told us it was important to do this, along with monitoring the patients' weight, to ensure they were taking in enough calories.
- Patients who were able to drink had a jug or cup of water left within reach. Hot drinks were also offered to patients at regular intervals by nursing or catering staff.
- Staff told us patients on a fluid restriction due to their clinical condition had their fluid intake and output closely monitored by nursing staff so their overall fluid balance could be accurately calculated throughout the day. We saw this in practice on the unit and staff were able to demonstrate how the fluid balance was calculated.
- Nasogastric (NG) tubes were inserted for patients who had been identified as requiring enteral feeding. Staff described tests which took place to ensure the tube had been inserted correctly, including a pH test and completion of a chest x-ray.

Patient outcomes

- The critical care unit contributed data to the 'Intensive Care National Audit and Research Centre' (©ICNARC) database for England, Wales and Northern Ireland. This meant care delivered and patient outcomes were benchmarked against similar units nationally. ICNARC data quoted relates specifically to the period from January to June 2015.
- The critical care unit also contributed to the North West London Critical Care Network which enabled further outcome and quality benchmarking, specifically against other local critical care units.
- There was an audit programme in place to ensure audits of key performance criteria were completed at appropriate intervals, which was in line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- ICNARC data demonstrated the percentage of patients predicted to die during their critical care admission was higher than the UK average. Staff told us this was due to the type of patients admitted to the unit. ICNARC

showed the mortality rate and standardised mortality ratio were in line other similar units. According to ICNARC data, there was a lower frequency of post unit hospital deaths than in other similar units.
- Fewer patients died within the first four hours of their critical care admission than on other similar critical care units according to ICNARC data. There were more patient deaths after seven days of critical care admission than on other similar units, although this was an improving trend.
- According to ICNARC data, there were generally more readmissions to critical care within 48 hours of discharge than in other critical care units, however data from the North West London Critical Care Network showed the unit performed better than most other units in the local area between April and June 2015.
- ICNARC data demonstrated there were generally fewer readmissions to critical care after 48 hours of discharge than in other similar units.
- Data provided by ICNARC showed approximately 30% of patients discharged from the critical care unit experienced a reduction in their level of independence upon discharge from hospital, however almost all patients returned to their preadmission residence.
- Between April and September 2015, four patients met the criteria for potential organ donors and two of these eligible patients were referred to the specialist nurse for organ donation (SNOD). Of these patients, one family consented to organ donation.

Competent staff

Nursing Staff:

- New nurses on the unit initially worked as supernumerary members of staff, until their supervisor signed off a series of basic competencies. whichThis meant they were then able to care for straight-forward patients independently. For more complex patients or those with specialist nursing needs, more advanced competencies had to be completed. For example, there were a set of competencies concerned with the care of patients with a tracheostomy.
- Additional competencies were in place for band six and band seven staff which encompassed more managerial tasks such as staff management and shift leadership. Staff told us competencies were used to guide their learning and helped them to progress professionally.
- One full time practice development nurse (PDN) was in post to support the learning needs of staff on the critical care unit, which was in line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. The PDN also supported student nurse placements and the development of the critical care outreach team.
- The Faculty of Intensive Care Medicine Core Standards for Intensive Care Units recommends 50% of critical care nurses should be in possession of a post registration award in critical care nursing. Additional critical care nursing awards had been achieved by 80% of nursing staff on the critical care unit. Data from the North West London Critical Care Network showed this was a higher proportion than most other critical care units in the local area. The PDN told us more nurses were booked to complete the course in the next year.
- Advertisements for internal and external training courses were placed on a noticeboard outside the staffroom. Courses included venepuncture and cannulation, adult ventilation and Schwartz rounds. Staff told us they were supported with opportunities for courses and additional qualifications. Two nurses we spoke with told us they were booked to attend the adult ventilation course.
- Nursing staff told us they received ad hoc bedside training from the duty consultant at times and valued this opportunity for learning.
- Student nurses were allocated a junior and senior mentor and this information was displayed on the student nurse information board. Details of weekly training sessions were also displayed. Students told us they were well supported by their mentors and received an excellent level of teaching and supervision.
- Agency nurses received orientation to the critical care unit and told us they were well prepared to work on the unit. Competency checks were done by the nursing agency; and additional documentation was completed during the agency nurse's first shift on the unit by senior staff to ensure they were working to the level required by the trust. One agency nurse told us they had last worked on the unit four months previously and had not received another induction at the start of their shift that morning. Staff were unclear how frequently agency nurses should be re-inducted if they had not worked on the unit for a period of time.
- Staff told us they had appraisals with their line manager, however few staff knew when their last appraisal took

place. Records showed appraisals were up to date for 48.33% of critical care staff. Senior staff told us this was lower than they wanted and had recently started a "big push" to get to 75% by the end of 2015.

Medical Staff

- New medical staff completed the generic trust induction which was attended by all new staff. In addition to this, they were inducted specifically to critical care which included orientation to the unit and an overview of working practices, such as times of ward rounds and the multidisciplinary meeting. Staff told us their transition onto the unit had been smooth and they were well supported when they started working within critical care.
- Junior doctors received three hours per week formal training and had opportunities to lead sessions or present research to the group. Staff told us ad hoc training sessions led by the consultants took place frequently, such as in relation to a specific patient or certain medical condition(s).
- One consultant we spoke with was passionate about teaching and medical staff development. This consultant was very keen for critical care at Ealing Hospital to receive specialist trainee doctors and to be recognised for the learning opportunities provided within the unit.

Multidisciplinary working

- A multidisciplinary team (MDT) ward round took place each morning, with attendance from the medical team, nurse in charge and pharmacist as a minimum. Staff told us the ward therapists also attended when possible. We observed a ward round which facilitated contribution from all members of the team where appropriate.
- A weekly MDT meeting was held to discuss all patients on the critical care unit. This meeting was led by the medical team and was also attended by the consultant due to take over responsibility for the unit the following week. There were representatives from radiology, pharmacy, infection control, infectious diseases, dietetics and microbiology. Staff told us the meeting was usually also attended by the critical care physiotherapy team. We observed a thorough and systematic approach to discussions within the MDT meeting. The atmosphere was informal but productive and encouraged constructive challenge from all attendees.
- Physiotherapy staff worked closely with their nursing and medical colleagues to create rehabilitation plans to address ventilator weaning (when patients' reliability on breathing machines is reducing and they are able to do more breathing on their own) as well as the physical rehabilitation. Staff told us it was important patients got sufficient rest between each of their daily activities and so it was essential to communicate effectively with the multidisciplinary team.
- We noted the critical care team liaised with other critical care centres, particularly specialist services, for guidance and advice regarding patient management. One staff member told us the critical care team were very open to help provided from other units and this process was invaluable for optimising patient care.
- Senior nursing staff described how they had worked with ITU at Northwick Park Hospital and the trust tissue viability teams to improve care of pressure sores.

Seven-day services

- Consultant-led ward rounds took place twice each day including at weekends, which was in line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. Consultants were available on the ward throughout the day and provided on call support to the overnight doctor, with a response time of 30 minutes.
- The critical care outreach team was available via a bleep referral system 24 hours per day, seven days per week.
- Diagnostic imaging was available at all times within the hospital, with an emergency on call bleep for out of hours cover. Staff told us there were no issues with accessing imaging at the weekends or out of hours.
- Physiotherapy was available from 8:30am to 4:45pm Monday to Friday, which offered a full rehabilitation and respiratory service. Over the weekend, respiratory patients were reviewed by the on call team and some rehabilitation patients would be seen if time allowed. Out of hours, an on call physiotherapist was available to assist with urgent respiratory therapy with a 45 minute response time.
- Staff told us there was little occupational therapy (OT) presence on the unit and most rehabilitation was

completed by the physiotherapists. We did not see an OT on the critical care unit during our inspection. Senior staff described how they would like a greater involvement of therapists on the ward to help patients reach their potential more quickly.

- Speech and language therapy (SALT) support was available from Monday to Friday via a bleep referral system. Staff told us accessing SALT support could be difficult as they were "extremely busy" but they always provided good support with tracheostomy patients.

Access to information

- We noted all patient notes were removed from the critical care for discussion during the weekly MDT meeting. This meant notes would not be immediately available in the event of a medical emergency. Staff told us this had been assessed as an acceptable risk as the notes were not geographically far from the unit and could be brought back quickly if needed.
- Patient investigation results, including blood tests and diagnostic imaging, were available on computer systems and were manually copied onto patient records, which could potentially cause errors during the transcribing process, although no incidents had been raised relating to this.
- A cupboard on the unit entitled "ITU Library" contained various folders of information for staff. The ITU Guidelines folder was divided into specific topics, such as sepsis and ventilation, and contained trust policies and other guidelines relating to patient care. Copies of the unit's ICNARC reports were available along with a communication resources folder and information about caring for patients with a learning disability.
- The clinical lead consultant set up a reference web site with copies of 5500 research articles split into relevant critical care headings. This web site was accessible via log in and password system and all staff were able to access this if they wished. The consultant maintained the web site independently and ensured data on the site was kept up to date. Staff were very positive about this website and described it as "an extremely valuable resource".
- When patients were transferred to other units or stepped down to a ward within the hospital, a verbal handover took place between the relevant nursing staff and also between the medical team. There was additional written information provided to the receiving area and the medical notes were transferred with the patient.

Consent, Mental Capacity Act and DoLS

- Staff throughout critical care were aware of the principles of the Mental Capacity Act and understood patients should be presumed as having capacity until proven otherwise. One nurse explained how patients with capacity were able to make "unwise" decisions even if the decision potentially had unfavourable consequences,. fFor example, refusing blood thinning medicines might cause a deep vein thrombosis. However patients with capacity could make that decision and accept the risk of thrombosis.
- Staff knowledge of consent was variable within the critical care unit. Some staff accurately described consent principles, including best interest decisions for patients who did not have the capacity to consent to procedures; whereas other staff told us they would obtain consent from the patients' families for invasive procedures such as tracheostomies, which .u We observed the correct consent forms were used where required despite the variability in staff knowledge.
- We observed staff asking patients for verbal consent prior to interventions such as positional changes and taking blood. Staff took care to explain why the intervention was required and we observed staff explaining the risks of not completing the task. For example, we observed a patient refuse to be turned in the bed and so the nurse then explained it was necessary to prevent pressure sores which made the patient change their mind and consent to the move.
- Knowledge and understanding relating to Deprivation of Liberty Safeguards (DoLS) was variable on the critical care unit. Some senior staff on the unit told us they had never heard of DoLS and others explained the implementation of DoLS on critical care was still "up for debate" and was not yet embedded on the unit.
- Substantive nursing staff generally had good knowledge of DoLS and were able to provide examples where applications had been submitted for certain patients. Agency staff on the ward told us they were not required to action DoLS requirements as they worked on the unit sporadically.

Critical care

Are critical care services caring?

Good

The critical care service was caring and supported patients to be involved as partners in their care. Staff treated patients with respect and compassion, and maintained patient privacy and dignity during all interventions. Staff helped patients and those close to them to cope emotionally with the care and treatments provided, offering reassurance and encouragement when needed. Staff spent time providing explanations to patients and helping them to make decisions about their own care.

Patient and relative feedback was positive. However some comments on feedback forms suggested care was not always at the level expected by patients. These comments were in the minority. We observed one example where a private conversation with relatives was held in the ward corridor which was not an appropriate space for this and could compromise patient confidentiality.

Compassionate care

- Patients provided positive feedback about all levels of staff on the critical care unit. They told us staff were friendly and made them feel as if "nothing is too much trouble".
- Staff addressed patients and their relatives respectfully and in a considerate manner. We observed staff chatting to patients' visitors and updating them about the patients' day, including any changes to their care.
- Privacy and dignity was maintained by all staff involved in patient care. We observed staff taking time to ensure patients were suitably covered up when sitting out of bed in their chair and during physical assessments on the medical ward round. Doors to patient rooms were kept closed and blinds were pulled down.
- Patients and their visitors told us staff were concerned for their comfort and offered extra pillows or blankets if needed. Patients told us staff asked about levels of pain regularly and provided analgesia "reasonably quickly" when needed.
- Staff spoke to unconscious patients when approaching the bedside and before completing any care tasks or interventions. We noted staff explained what they were going to do such as repositioning them even when there was no evidence the patient could hear.
- Relatives were confident about the care their loved one was receiving on the unit and told us the staff always did "everything they can" to make sure patients get better and had everything they need.
- We saw evidence of many thank you cards and letters which praised the service provided on the unit and the kindness of staff. Patients described staff as "stars" and expressed their gratitude for the care they received when admitted to the unit.
- Our Short Observational Framework for Inspections (SOFI) demonstrated multiple positive interactions between staff and patients, including asking patients about their pain levels, fetching a blanket when the patient was cold and usually explaining procedures before they were completed. We noted one negative interaction where the patient's dressing was changed without any explanation of the procedure.
- We observed a doctor providing an update about a patient to their relatives within the main ward corridor, which was not an appropriate place for the conversation and could compromise confidentiality.
- Patient feedback forms were given to patients approaching the end of their critical care unit stay. Most comments on these forms were very positive. However there were some comments made suggesting the care received by patients was not up to the level they were expecting and examples were provided, such as nursing staff chatting over a patient when completing care tasks.

Understanding and involvement of patients and those close to them

- We observed staff take the time to introduce themselves to patients and their visitors, explaining their role and why they had come to see the patient. Patients and their relatives told us they appreciated this because it could be "difficult to remember who everyone is".
- Patients and their relatives were involved in discussions about their care and we observed staff taking time to thoroughly explain any changes in the patients' medical condition and providing the opportunity for the patient or relative to ask questions. The medical team communicated with patients about their intended plan of care and checked the patient was in agreement with their initial plan. Patients were encouraged to make decisions about their care and we observed staff describing more than one plan of care to the patient, explaining the benefits of each and supporting the patient to decide which plan suited them best.

- We noted patients were put at the centre of care during ward rounds and staff addressed the patients directly, including speaking withto unconscious patients who could not communicate.
- Relatives told us they were not asked to leave during the ward round unless specific physical assessments were needed. They reported being involved in the care of the patient. They said staff were always willing to answer questions or find out information if they were not sure about something.
- Staff told us family meetings did not occur routinely but could be booked in if families could only visit at specific times and wanted to meet with the medical team. Staff told us they would do "as much as possible to give relatives all the information" they wanted.
- A Specialist Nurse for Organ Donation (SNOD) was based on ITU and worked closely with the critical care team to identify potential organ donors. The SNOD was introduced to relatives of potential organ donors who had been told their loved one was dying and provided information regarding organ donation. Staff told us the SNOD would remain involved in supporting relatives of these patients whether they decided to allow organ donation or not.

Emotional support

- Staff told us they offered emotional support as a matter of routine and this was a key part of being a critical care nurse. Staff told us patients and their visitors were often much more stressed when they were on the critical care unit rather than a regular hospital ward because patients were much more unwell. They told us this meant staff had to be particularly sensitive to the emotional needs of everyone on the unit.
- Patients told us staff were kind and sympathetic to their needs, empathising with their situation and offering support when needed. One patient described being extremely nervous when having a CVC line removed and told us staff were reassuring and encouraging during the procedure. The patient told us a thorough explanation was provided and staff "didn't mind the extra hassle" of caring for a nervous patient.
- A chaplaincy service was available 24 hours per day, seven days per week. The team offered spiritual or religious support to patients, relatives and staff members alike.
- The SNOD provided support for bereaved families where appropriate and assisted them in obtaining certain keepsakes from their loved ones such as a lock of hair and hand prints.
- Staff on the critical care unit told us they were aware of external support organisations which could be accessed by patients and relatives if required. hHowever they were unable to provide examples when requested. Staff told us they would use the internet or the expertise of their colleagues if they needed to signpost a patient or relative to a support service.

Are critical care services responsive?

Requires improvement

The responsiveness of the critical care unit required improvement because services did not always meet people's needs. There was a shortfall in critical care capacity and we noted occupancy rates were almost always above 95%, which is considerably higher than the recommended 70% critical care occupancy. We noted some overflow of critical care patients into theatres recovery beds, although this only affected a small proportion of patients and there had been no elective procedure cancellations as a result of this. There were more delayed discharges, and out of hours discharges from the critical care unit than in other units locally and nationally, which staff attributed to difficulties with accessing ward beds within the hospital. We also noted a high number of clinical transfers from critical care so patients could access specific treatments at other centres. There wasere no follow up clinics available to patients after discharge from the unit and facilities for visitors were limited.

There was good support for patients who needed information in other languages as well as patients requiring psychiatric support and those with a learning disability. Patients and relatives could make informal complaints at ward level or were supported to access patient advice and liaison services within the hospital to follow the formal complaint pathway. There had been no complaints recorded between April and October 2015.

Service planning and delivery to meet the needs of local people

Critical care

- The majority of admissions to the critical care unit were unplanned medical admissions (76% of patients). The remaining 24% were patients admitted following surgery, of which 58% were emergency cases and 42% were elective procedures.
- Difficulties in planning service delivery were identified by staff due to the high number of unplanned admissions from the hospital wards and emergency department to critical care, which was difficult to anticipate.
- Patients undergoing elective surgical procedures would usually have beds booked on the unit if the anaesthetist or surgeon caring for that individual judged the patient would require additional support postoperatively. Beds were booked with the critical care nurse in charge as far in advance of the patient's admission as possible. Critical care staff told us they allowed a maximum of 2 booked admissions each day to allow for admission of unplanned patients.
- Most patients (68%) who accessed the critical care unit required level three support and the remaining patients required level two support.
- ICNARC data from January to June 2015 showed there were more clinical transfers out from the critical care unit than in other similar units nationally. Staff told us some patients had to be transferred from the unit so they could access certain types of medical treatment, for example extracorporeal membrane oxygenation (ECMO), which were not offered in the critical care unit at Ealing Hospital. This was typical of the type of critical care support provided within a district general hospital.
- No follow up clinic was provided for patients who had been inpatients on the critical care unit, which was not in line with recommendations from the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units. Senior staff on critical care were aware of the need for a follow up clinic and said this would be a valuable addition to the service provided to the unit.
- No accommodation was provided for visitors to patients on the critical care unit, even if they lived a long way from the hospital or had difficulties accessing the hospital via public transport.

Meeting people's individual needs

- Visiting times for unit were between 10am and 7pm, with a one hour quiet period for patient lunch and rest. Staff told us they allowed flexibility for families who had difficulties visiting during the allocated times and this was agreed and arranged on a case by case basis.
- A small waiting area was provided for visitors to patients on the critical care unit and we noted visitors over spilling into the corridor as there was not enough space in the waiting room at times. The waiting area was located near the lift and stairwell area, away from the unit. We observed visitors trying to access the critical care unit and being told their relative would not be ready for visitors for another ten minutes and having to walk back to the waiting area. The same relatives had received no communication from staff 20 minutes later and walked back to the unit for an update. We noted this could cause difficulties for visitors with mobility or other health difficulties.
- Information leaflets about the critical care unit were provided at the entrance in several different languages such as Urdu, Hindi and Punjabi. Other languages were available upon request.
- Staff demonstrated their awareness of the needs of different cultures and religions by describing how differently certain groups viewed the management of dying patients as well the possibility of organ donation. Staff told us they respected the beliefs of different cultures and religions but tried to do what was best for the patient and support the relatives accordingly.
- Patients who were Jehovah's Witnesses wore wrist bands which identified they should not be given any blood products, in line with their religious beliefs.
- Psychiatric support for patients was provided by the psychiatric liaison team who reviewed patients demonstrating challenging behaviour, symptoms of delirium and with any other mental health needs.
- One staff member told us about the 'Treat Me Right!' initiative which ensured equal access to healthcare services for patients with a learning disability. They told us advice about caring for a patient with a learning disability could be obtained from representatives within this organisation. In addition to this, staff told us they would seek support from senior members of the team, as well as the individual patient's friends, family and carers. One staff member told us they had made contact with a patient's community learning disability support team to find out more about how best to communicate with that patient.

Critical care

Access and flow

- The North West London Critical Care Network data for April to June 2015 demonstrated critical care at Ealing Hospital had a capacity shortfall in line with other units in the network. At the time of our inspection, there were no plans in place to address the shortfall in critical care beds at the hospital.
- Occupancy of beds within the critical care unit was almost always above the optimum 70% capacity level identified by the Royal College of Anaesthetists. The recommended occupancy rate allows for units to be able to take in more patients should there be an emergency. If a unit is at a higher occupancy, it is unable to respond to emergency admissions and may find they are required to step-down patients too early or transfer patients to other hospitals out of their locality. Occupancy was usually at 95% and above 100% at times between July 2014 and January 2015.
- Staff told us it was sometimes necessary for the critical care unit to overflow into the theatres recovery beds and this occurred more frequently over the winter months. Hospital data for January to July 2015 demonstrated this overflow affected 6% of critical care patients admitted to the unit.
- There were no elective theatre procedures cancelled between January and July 2015. Staff told us there used to be "several" cancellations each month but this had now improved as patients would be nursed in the theatres recovery area while waiting for a critical care bed if needed.
- Faculty of Intensive Care Medicine Core Standards for Intensive Care Units advises patients should be transferred to ITU within four hours of the decision to admit. The critical care team told us this data began to be formally audited in October 2015. At the time of our inspection, the admission of ten patients had been recorded and this showed 90% of patients were admitted in less than three hours which was in line with recommendations. The remaining patient was admitted to critical care after a wait of six hours and 15 minutes. Staff told us the unit was at maximum capacity when this patient needed admitting and so the delay was caused by making a suitable bed available.
- Patients generally stayed on the critical care unit for slightly longer than in other similar units, according to ICNARC data from January to June 2015. Staff attributed this statistic due to the number of delayed discharges from the unit. However information from the North West London Critical Care Network showed length of stay was in line with other critical care units in the area.
- Between January and June 2015, ICNARC data showed the number of early discharges from the critical care unit was in line with other similar units. There were more delayed discharges from critical care than on other similar units according to ICNARC data. Staff explained delayed discharges occurred due to the availability of beds on the hospital wards.
- Patients discharged from critical care 'out of hours' between 10pm and 7am are nationally associated with worse outcomes and ICNARC data from January to June 2015 demonstrated there were generally more out of hours discharges from critical care than in other similar units, although this improved on the last quarter of data collection to less than the national average. Data from the North West London Critical Care Network showed there were slightly more out of hours discharges than on other critical care units in the local area.
- ICNARC data from January to June 2015 showed there were more clinical transfers out from the critical care unit but less non-clinical transfers than on other similar units. Staff told us there were no non-clinical transfers during this period.

Learning from complaints and concerns

- Informal complaints were managed at ward level or patients and their families would be directed to the patient advice and liaison service PALS) within the trust to log formal complaints. Staff noted informal complaints via the incident reporting system.
- We noted several posters throughout the unit, including within the visitors' waiting area advertising the services of PALS and displaying contact details for this service. Staff told us they encouraged patients and their relatives to raise any issues or concerns as quickly as possible so they could be dealt with efficiently by staff on the ward or escalated if appropriate. One staff member told us she had supported a patient to speak to a PALS representative on the critical care ward.
- There were no informal complaints logged by staff between April and October 2015 and no formal complaints received via PALS during the same period.

Are critical care services well-led?

Critical care

Good

The critical care unit was well-led and the leadership promoted the delivery of high quality person-centred care. There was uncertainty regarding the future of the critical care service, however the service management had developed a vision and strategy to develop the service within its current form, with an on-going focus on quality and safety. The measurement of quality was on-going we saw some evidence of innovation such as the development of the high flow oxygen service. Good governance processes were in place with dissemination of relevant information to the critical care staff; however there was limited shared learning with other departments and across the critical care sites within the trust.

Staff were positive about the leadership of the critical care service and told us the department's managers were visible and approachable. The culture on the unit was one of openness and honesty, with constructive challenge welcomed. There was evidence of some staff engagement within the service but limited public/patient involvement.

We did not receive a copy of the departmental risk register but staff told us the patient monitors were the only item on the register; this was not appropriate and other issues identified during our inspection should have been listed for example the high occupancy rates within the unit. There were no strategies in place to address the high level of occupancy and occasional overspill into the theatres recovery beds.

Critical care management staff were vocal about their poor relationship with trust management and reported that they had been forced to adopt methods of practice from the Northwick Park Hospital site following the merger. There was a sense of being undervalued as a department by trust management and a lack of understanding about the service provided by critical care.

Vision and strategy for this service

- There was a feeling of uncertainty regarding the future of the critical care service at Ealing Hospital. Senior staff described belief that the formation of one large critical care unit to cover all hospitals within the trust was inevitable. They told us the unit at Ealing had a lot to offer to the trust and to patients within Ealing Hospital, including those who attend the emergency department. Although staff admitted to finding the prospect of a merged unit disappointing, they highlighted the opportunities for research and quality improvement this could bring.
- Staff on the ward were of the opinion that the future of the critical care service was “up in the air” and were unsure whether it would continue. They said the situation made them worry about their jobs and some staff told us they did not want to be transferred to one of the other hospitals in the trust if critical care at Ealing Hospital was stopped.
- Senior staff were keen to stress they still had visions in place for the current critical care service. They explained they were very proud of their patient outcomes as well as their safety record and they were very keen to improve both of these quality indicators through additional training of staff and development of practice. Staff described how more staff were booked to complete a critical care nursing course as well as other courses and there was a big drive to complete appraisals and mandatory training to ensure staff competence.
- Senior staff reported that visions for the critical care unit had been developed in isolation without input or support from senior management within the trust. They were of the opinion that developments and investment in the service would not be supported and had made independent plans to ensure the service was continually improving.
- Ward staff were aware of the drive to continually improve the quality and safety of the service on the unit but told us they did not see a clear strategy for achieving this due to the uncertainty surrounding Ealing Hospital’s future.

Governance, risk management and quality measurement

- The governance processes for the critical care unit completely fulfilled the five requirements of governance quality measure as reported by the North West London Critical Care Network.
- Monthly governance meetings explored the incidents reported in the previous month and identified any trends. Actions to address trends were identified.

Morbidity and mortality were also discussed, during which the care of any patients who had died on the unit was analysed to identify learning points and quality improvement.

- Governance issues were communicated to ward staff during staff meetings and handovers if appropriate. Staff said they received sufficient information relating to the governance processes on the unit. Senior staff told us they were always looking to improve the communication and consciously tried to make governance information engaging and relate it to case studies to "help get the message across".
- There was no evidence of shared learning between the critical care unit and other units within the hospital or other areas of critical care within the trust. Senior staff told us this was a valuable and a wasted learning opportunity, however neither department had instigated processes to begin shared learning, attributing this to resistance from their opposite number.
- The departmental risk register was maintained by senior staff on the critical care unit. We did not receive a copy of the risk register despite requesting it. However staff told us the only item it contained was the patient monitors which needed replacing. This would not accurately reflect our inspection findings, as we would also expect the capacity issues and potential closure of the unit to be listed as risks.
- The quality of the service provided by critical care was measured continually and frequently benchmarked against the performance of other units via the ICNARC reports and critical care network quality measures report. Involvement in both benchmarking processes was well established and had been in place for several years. Quality of performance measuring data was analysed by ICNARC which ensured the information quality reports were based upon were accurate, valid and timely.
- Quality measures from ICNARC and the critical care network were reviewed within quality meetings attended by senior critical care staff on a quarterly basis. During this meeting unfavourable trends were identified and action plans for improvement identified. Additionally, areas of good performance were analysed to sustain quality.

Leadership of service

- The medical and nursing leadership teams on the critical care unit were formed of several very experienced members of staff, who had considerable critical care expertise. These members of senior staff were allocated specific time to complete their leadership duties, including service development, governance and people management. Most staff said they had adequate time to fulfil their responsibilities.
- Recommendations from the 'Faculty of Intensive Care Medicine Core Standards for Intensive Care Units' stating there must be a designated clinical director and an identified lead nurse in critical care were met. Additional nursing leadership was provided by the supernumerary charge nurse on each shift.
- The critical care leadership team were vocal and honest about the difficulties faced by the service at the time of our inspection. They demonstrated where actions were in place to address these issues and acknowledged where shortcomings within the service lay.
- Senior staff described a disconnection between the leadership of the critical care unit and senior management within the trust. Staff believed the trust management had little understanding of the critical care service and made changes to practices throughout the hospital without knowing any background information behind the decision. They described an example where the number of overnight on call medical staff in the hospital was reduced without any consultation with staff and this placed patient safety at risk. The trust management was presented with data supporting the need for anthe additional on call person and reinstated the post two weeks later. Staff said this issue could have been avoided if there had been consultation with clinical teams within the hospital prior to removing the on call post.
- Ward staff told us the critical care leadership team was frequently visible on the wards and always approachable. Staff told us they would feel comfortable raising any worries with the leadership team and believed their concerns would be listened to and acted upon if necessary and possible.

Culture within the service

- Ward staff reported feeling valued by the critical care leadership team and believed successes on the unit were attributed to the team as a whole. They told us they were encouraged to have honest and open

conversations with other members of the team, including challenging the medical management of patients if they disagreed with treatment plans. During the weekly MDT meeting, we noted a relaxed and friendly atmosphere which positively encouraged constructive challenge and questioning from all members of staff.

- Agency staff told us they were valued by their substantive colleagues and said they were made to feel like part of the permanent team, who were described as being friendly and welcoming.
- Staff perceived that the merger with Northwick Park Hospital had been more like a takeover and described how they had been made to adopt certain protocols based upon those used in critical care at Northwick Park Hospital instead of their own. They were of the opinion that this undermined their past performance and the service provided by the critical care unit at Ealing Hospital.
- Senior critical care staff told us trust management completed intermittent "walk arounds" where they would go onto the critical care unit. Staff told us they did not value these visits and felt they received undue criticism and little praise afterwards.
- Some senior critical care staff were hesitant to raise concerns with senior trust staff as they were concerned about the repercussions this might cause. Staff said they sometimes used a colleague as a 'spokesperson' to raise issues, with support from the senior critical care team.
- We were told of recent resignations from senior critical care staff and we saw evidence suggesting the reasons for resignations were largely due to the perceived poor relationship between the critical care service and senior management within the trust.
- Senior critical care staff told us they valued their colleagues and had good working relationships on the unit. They felt these good relationships did not extend to the critical care team at Northwick Park Hospital and told us there was very little interaction between the units.

Public and staff engagement

- Patient feedback was obtained via feedback forms specific to the unit. Patients and their relatives had the opportunity to rate a number of different aspects of the care on the unit and a free text comment box for any additional feedback not covered by other questions on the form. Feedback forms were compiled on a monthly basis and any themes were identified then disseminated to ward staff for praise or improvement plans as needed.
- Staff were engaged in decision making relating to unit changes by the critical care management team. For example, as the old patient monitors required replacing, several new models were trialled and staff had the opportunity to test each model and provide feedback about their preferences.
- Results from ICNARC reports were explained to staff to help them understand how the unit was performing in relation to other units nationally. Staff told us this helped with motivation and was useful to guide their focus on clinical care and performance.
- Staff achievements such as course completion or promotion were reported in the trust newsletter which was disseminated throughout the trust. Acknowledgement of personal achievements were also identified during staff meetings. Staff told us they appreciated their achievements being recognised and it made them feel proud.

Innovation, improvement and sustainability

- Staff described hopes to further develop a high flow oxygen service which would be overseen by critical care staff but delivered on the medical wards. Staff felt this additional level of ward treatment might help reduce medical admission and help offset some of the capacity issues.
- A business case had recently been approved by the trust to increase the provision of critical care outreach in the hospital to 24 hours per day, seven days per week. Staff told us this would enable them to appoint new substantive outreach staff and reduce the use of agency staff on critical care due to the use of ward staff to backfill the outreach shifts.
- Staff described the need for a critical care follow up clinic but explained no steps had been taken yet to put this service in place. Staff told us they felt it was unlikely to be supported by the trust as the needs of critical care patients were not understood by senior management.
- Senior staff described their hopes of having specialist trainee doctors in post on the unit and having the unit formally acknowledged as a training location. Staff were passionate about educating junior doctors and felt there were suitable learning opportunities within critical care for it to be a valuable placement.

Critical care

- Some cost saving initiatives were in place on the unit, for example senior staff described how the consumable procurement process had been streamlined and a list of approved suppliers provided to keep costs down. Staff told us senior staff management time had also been reduced in an effort to get staff "out of the office and onto the shop floor". Staff were supportive of this change and did not feel this had had a detrimental effect on their ward management role.

Services for children and young people

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

Information about the service

Ealing Hospital has one inpatient 20-bedded ward on level 10 named 'Charlie Chaplin', which has a secure playground on the roof terrace for children to play and a conservatory for parents to relax. Children and young people with a variety of medical and surgical related conditions between the ages of nought and 16 years are cared for on the ward.

Princess Amelia Ward is the 6 bed day care unit (based on level 10 opposite Charlie Chaplin ward), where children and young people having minor operations, special investigations and treatments, are cared for.

There is a designated paediatric resuscitation area in the emergency department and a 4-bed Clinical Decisions area dedicated to children.

We spoke with 6 children and their parents or guardian, 23 staff including nursing staff,medical staff, play specialists, ward housekeepers and administrative and managerial staff.

We reviewed 10 sets of patient medical and nursing records and information requested by us and provided from the trust.

We inspected all the areas above including the transition arrangements for children transferring into adult services and the provision of care for children with long term conditions such as diabtes, epilepsy and asthma.

Summary of findings

Children and young people's services overall requires improvement but the service is considered good for caring. We found out of date policies still in use, Control of Substances Hazardous to Health (COSHH) assessments not completed and chemicals found stored in an unlocked cupboard in an unlocked cleaning room in the children's ward.

There were staff shortages in some areas with a high use of agency or bank staff covering for sickness and additional leave. There was evidence of some transitional arrangements for moving children from children into young adult then adult care. Senior staff had to seek out numbers when children were admitted to an adult bed, as there was no flagging system.

There were gaps in support arrangements for children with long term conditions e.g. epilepsy and no identified nurse specialist to support this group of patients who required information and support with this potentially life changing development.

The service was not responsive to meeting the needs of children and young people when in the children's accident and emergency department as the waiting time was reported as too long by parents seen. The children's waiting times data was requested from the trust but not received.

Services for children and young people

We were informed of the future change for the service which had been developed. Eight staff were spoken to by the inspectors of which two staff members were not aware of the local or trust strategy.

The arrangements for governance and performance management did not always work effectively as items on the risk register did not reflect all the areas that require improvement identified by the inspectors. These risks were dealt with immediately when raised by the inspectors.

Leadership within the service was rated as requiring improvement. Staff informed us that managers had not always been visible on this site since the movement of managers to the Northwick Park site.

The safeguarding children's procedures were robust with staff demonstrating how they were embedded into the service.

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

93% of children were seen within 18 weeks of referral for treatment. Services were planned and delivered to meet the needs of the diverse population.

There was an accident and emergency escalation policy for paediatrics which was designed to prevent excessive waiting times for children.

Are services for children and young people safe?

Requires improvement

Safety of the children's service required improvement. Although the safeguarding children's procedures were embedded and robust, other policies and procedures required review and updating. The safeguarding children's policy was also currently under review and the existing out of date policy was seen as a printed hardcopy across the service.

We found out of date policies still in use, Control of Substances Hazardous to Health (COSHH) assessments not completed and chemicals found stored in an unlocked cupboard in an unlocked cleaning room in the children's ward.

There were staffing shortages for registered staff across the service with excessive use of agency staff in July and August 2015. We had been informed that recruitment was a problem with the future commissioning changes with the service. Work was needed to stabilise the staffing base and reduce staff sickness. We saw the electronic roster for the past month and were told by staff who had worked extra bank hours. That they worked these extra hours on top of their permanent contracts to reduce the need for agency staff.

There was good evidence of record keeping and completing paediatric early warning signs (PEWS).

Incidents

- One never event had been reported in children's accident and emergency when the registered children's nurse (RSCN) was escorting a seriously ill child to the other acute site. This resulted in an eight-week-old baby being given an oral dose of antibiotic intravenously by an adult trained nurse not following the medication policy. "Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented."
- The children's service reported 32 serious incidents (NRLS) through the online reporting system, called Datix

between June and September 2015. The most common reported incidents were staffing levels not meeting children's acuity or dependency and issues with the administration and recording of medicines.

- We saw 871 incidents reported since August 2015 across this integrated service. The identified incidents related to staffing, discharge letters and interpreters not present which led to a cancelled appointment. We saw no evidence of sharing lessons learned across the trust.
- oftenminimal.We reviewed several incidents reported for this service through the Datix electronic reporting system with the root cause analysis and completed recommendations. On review of the incident reports submitted, the action taken in response following an investigation was often not detailed and not presented in 'SMART' style. One example was when an agency staff member did not turn up for a shift. The action was that the nurse in charge persuaded a permanent member of staff to cover the shift but the record did not state actions taken by temporary staffing with the management of the agency.
- We reviewed the ward meeting minutes for July and August 2015 and there was no record of incidents or shared learning seen.
- Staff we spoke to were aware of the requirements of reporting incidents and when and how to complete an incident reporting form.
- Incident reporting and learning was shared across the service and the wider trust. Staff minutes confirmed the Datix reporting system had merged as expected in October 2015.
- There were incidents seen that met the requirements of Duty of Candour. Staff were able to articulate the requirements of Duty of Candour and actions taken when this had been completed. Senior staff confirmed that they spoke with families involved in incidents when appropriate as part of the standard practice of being open following an incident
- The medical and nursing staff in the service attended mortality and morbidity meetings currently held monthly with 'everyone welcome' to a Skype link meeting. The last meeting was held in September 2015; those minutes demonstrated that the Skype link information technology system stopped working during the meeting
- The ward's quality board gave an example where a child's care did not go as planned and the additional training provided for staff to reduce the risk of reoccurrence.

Cleanliness, infection control and hygiene

- There were strict processes in place to prevent the potential spread of methicillin resistant staphylococcus aureus (MRSA). Testing for MRSA was standard, if a child had previously tested as positive, they were nursed in a side room until two negative results had been obtained.
- Monthly infection prevention and control (IPAC) audits took place across this service The audit included hand hygiene, standard precautions, care of peripheral vascular device insertion and continuing care, patient equipment and environment. Methicillin Resistant Staphylococcus Aureus and Clostridium difficile audits were completed monthly and displayed. Cleaning scores for each ward from local audits were compliant. However, there was limited evidence of cleaning schedules across the service.
- A monthly infection prevention and control safety cross was on display across the service. The cross demonstrated how many days the ward had been free of infection outbreaks for MRSA and clostridium difficile (CDiff) that month. In this case, every day had been free of these healthcare acquired infections. There have been no reported cases of identified for children's and young people's services.
- Staff during the inspection at this hospital were compliant with "bare below the elbows practice" and wore their uniform with new lanyards and badges in line with the trust merger senior staff uniforms were different to Northwick Park staff in the equivalent role Compliance with key trust policies was observed and an internal audit stated a 100% Hand Hygiene compliance level.
- When asking two members of staff to identify the infection prevention and control lead for their area, they were not able to do so.
- Disposable curtains were in use but on Princess Amelia day care unit, torn adhesive labels were attached, showing four curtained areas replaced on 7 Oct 2015.
- Eight Chloriclean tablets containers were found in an unlocked cupboard in an unlocked housekeeping room opposite the children's four-bedded bay on Charlie Chaplin ward. This issue was resolved immediately,

once inspectors brought this to the attention of senior staff. Senior managers reviewed and reduced stock levels, which are now in a locked cupboard and obtained a key for the cupboard on the ward, which we were assured would remain locked.

Environment and equipment

- The environment on leaving the lift at level 10 was clean and free of any clutter The entrance to level 10 'Charlie Chaplin' children's ward area was secure The entrance to level 10 'Princess Amelia' day ward area had automatic opening doors with CCTV in position across four points of the corridor.
- CAMHS patient quiet room on Princess Amelia had no call bell, nor any evidence of risk assessment completed to support staff safety when dealing with potentially aggressive children
- Clinell "I am clean" green stickers were used on equipment and seen across the service
- Resuscitation equipment was checked daily with completed checklists in place.
- Equipment was found to be clean and where required an electrical safety test was completed and labelled to show when the equipment was checked as safe.
- Bed mattresses examined were new with no visible soiling. The process of when they were checked was identified. Some beds seen were numbered but we were not told why all beds did not have this system. This means that some beds could be missed with maintenance checks.
- Equipment was stored in the OP cubicle area with only one piece of equipment having a completed decontamination form.
- A fridge containing staff food on Princess Amelia was found with no temperature recordings since Sept 2015. Senior staff we discussed this with said they were not aware of who was responsible for this check. Senior staff informed us this is now undertaken by the housekeeper.
- A parent's fridge on Charlie Chaplin had no temperatures recordings for September, although daily recordings were completed for October showing temperature was 2-5 degree Celsius, which is within the accepted normal range.
- Non-disposable blood pressure cuffs were seen in use, staff assured us that cleaning had occurred between patient use.
- The Charlie Chaplin ward and CDU was secure entry by card to give restricted access
- The bath situated in the first washroom on Princess Amelia was badly stained and we were informed by senior staff that it had been recently reported for replacement. There was no signage showing "Not in use".
- The schoolroom appeared well equipped and captured the educational needs of children and young people of a mixed age range.
- The conservatory and outdoor play area were "tired" in appearance, we saw broken storage containers and flooring that was stained from the elements.

Medicines

- We observed a ward medication round which was completed by two RGNs wearing red tabards with "Do not disturb I am completing a drug round". Two staff members expressed concerns that they still had occasions to stop during the medication rounds if staffing levels meant no other staff on ward were able to assist parents or children.
- Antibiotic compliance was observed and checked daily by the children's specialist pharmacist.
- We checked six prescription forms, which were completed including weight, height and identified allergies noted.
- The Children's specialist pharmacist informed us she was due to leave the following week and senior staff could not confirm how this service would be covered.

Records

- Children had risk assessments completed on admission, which were evidenced in the six patient records examined.
- We saw completed care plans, which were updated and included pain scores.
- We were informed that GP discharge letters were sent out electronically but with the recent introduction of System[EG3]One, senior staff confirmed that they had not yet received training System One is a centrally hosted clinical computer system developed as one of the accredited systems in the government's programme of modernising information technology in the NHS.
- Hospital numbers were not recorded on every page of the medical records and a recent internal audit confirmed that only 64% of the notes were compliant.
- All COSHH assessments seen were out of date with the last assessment completed in 2005. The trust had updated its policy and changed the process in August.

Senior staff were unable to describe their responsibilities following this change, with the recent withdrawal of the information technology system called Sybol

Safeguarding

- The safeguarding children's policy is currently under review and the existing out of date policy was seen as a printed hardcopy across the service.
- The acute safeguarding groups report into the women and children's health directorate and inform other directorates as and when information from safeguarding is pertinent to a directorate
- The trust had a safeguarding children strategic group, which reported to the Trust Board.
- Monthly safeguarding meetings and a quarterly operational meeting took place in sub-divisions. Information from these was shared with the Clinical Performance and Patient Experience Committee. Child Sexual Exploitation and Female Genital Mutilation were amongst the areas covered by the strategic group.
- We reviewed the first quarterly report for Safeguarding Children, which related to the period April 2015 to June 2015. Information included: review of child deaths, (none at Ealing Hospital for the quarter), priority areas of work, training figures and governance and accountabilities.
- Safeguarding supervision was well established within the organisation. All paediatric nurses are able to access one to one supervision every three months.
- Staff we spoke with described the referral process and knew the names of the safeguarding doctor and lead nurse.
- The information technology patient system did not flag up any "at risk" children or children admitted across the hospital on an adult ward. Senior staff confirmed that admissions were physically sought through the site management team.
- Child protection issues were discussed at staff handover and with the wider team.
- Safeguarding training for staff was 68% at level three, 60% had received the training for level two and 97% of staff had been trained at level one as evidenced in the safeguarding children's annual report. Within outpatient services, 89% of staff had received safeguarding training at level three. This was against a trust target of 95%.
- Between April 2014 and March 2015, the service had undertaken 6,660 children's safeguarding consultations for referrals for child protection plans. This data was requested but not mentioned in the safeguarding annual report received.
- This service had a process for flagging up safeguarding children via I.T. on entry to the trust

Mandatory training

- The trust target for attending mandatory training is 95% with staff from children's services achieving 80%. Training for HCA completing mandatory training 78%. IV update training for staff was 80%. Infection control training compliance achieved was 78%.
- The organisation migrated from Wired in March 2015 to Education and Learning Management System (ELMS). ELMS provides staff with the opportunity to book their training electronically, record data and produce reports

Assessing and responding to patient risk

- The use of the paediatric early warning tools were seen in six children's records and were completed correctly in line with national guidance for PEWS. Staff were able to describe when they escalated a deteriorating child and actions taken.
- Staff confirmed they used the "SBAR" tool across the service. SBAR is a tool to use to ensure communication is effective when handing over or communicating with another healthcare professional about a process.
- Senior staff informed us that it was planned to extend the service provided by the rapid access clinic in future to seven days to support children and reduce A&E waiting times by enabling Ealing GPs to refer to a paediatrician.
- Staff attended advanced paediatric and neonatal life support training with 80% compliance across this service.

Nursing staffing

- The children's service vacancy for registered nurses was one whole time equivalent (WTE) band 7 and three WTE for support staff. Ealing had 16.66 WTE registered nurses (RGN)in June 2015 down from 20.66 WTE in Oct 2014.Charlie Chaplin ward band 7 vacancy was covered by matron.

Services for children and young people

- The RCN (Royal College of Nursing) acuity tool for safer staffing was used but senior staff confirmed there was difficulty in recruiting to the hospital.
- August and September 2015 safer staffing levels showed that the permanent RGN to bed ratio for day and night was 1:6 higher than the recommended 1:4 ratio for this service.
- The staff handover demonstrated a comprehensive approach.
- Skill mix details submitted via unify in line with safer staffing ratio was 70% RGN to 30% HCA.
- Bank staff came through existing team members working through the bank system (including induction processes for these staff groups)
- The electronic roster version 10 is used which links to temporary workforce. This meant there was no delay once staff amended the roster.
- We were told by senior staff that the trust were aiming to reduce agency staffing cover but currently, due to maternity and sickness leave, shift requests to fulfil staffing levels were covered by bank or agency staffing. Senior staff informed us this was covered by bank and agency staff who had worked on the ward before.
- We saw that staff were working bank shifts in addition to their own shifts to avoid the use of agency staff

Medical staffing

- We were informed there were 5.7 WTE consultant paediatricians for the service but there was difficulty in recruiting. There was one WTE vacancy. We requested information regarding staffing of other doctor grades but did not receive this.
- There was one locum middle grade and one locum working at Ealing in this service.
- The paediatric consultants were available on site Monday to Friday with consultant cover provided on Saturday and Sunday. During times when a consultant was not on site, there was a 24 hour on-call service available
- Medical staff spoken to confirmed consultants were supportive and accessible out of hours and at weekends
- A medical handover was observed and was well structured, open and comprehensive. All staff present were engaged and concerns raised were addressed.

Major incident awareness and training

- The children's service would respond to the trust major incident and business continuity plans on the trust intranet Staff had access to this information and senior staff knew they had action cards to follow.
- When speaking to the inspectors, staff described a recent experience of preparing to evacuate the ward area and actions taken. There was no evidence seen that a complete drill had been completed or that a recent formal practice had taken place.
- We saw the evacuation plan on the ward, no date was on the plan. This was brought to the attention of senior staff.

Are services for children and young people effective?

Good

We rated the service good in effectiveness. There was evidence of children and young people with good outcomes because they receive effective care and treatment.

Children and young people have comprehensive assessments of their needs, which include clinical needs, mental health, physical health and wellbeing and nutrition and hydration needs.

There was participation in local and national audit, including clinical audits and other monitoring activities, including peer review. This service recently participated in the national clinical audit for the initial management of the fitting child. The Royal College of Emergency Medicine (RCEM) standards were met except for standard 4, in which 0% was given (there was no written information from the child or parents).

Staff were qualified and had the skills they need to carry out their roles effectively in line with best practice. The learning needs of staff are identified and training is in place to meet these learning needs.

Most care and treatment reflected current evidence based guidance, standards and best practice. However, the children's day care unit surgery document did not. It was last updated in 2003 and codeine remained in the

analgesic ladder, which does not follow national guidance for children. The post-operative care plan did not include paediatric early warning system (PEWS). We were informed this was now added to the care plan.

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

Consent to care and treatment was obtained in line with legislation and guidance. Staff were able to demonstrate a good understanding of the Gillick competence and children were supported to make decisions where appropriate. Parents were also supported to make decisions where appropriate and offered information to make best interest decisions for their child in respect of treatment. The Gillick competence is a test in medical law to decide whether a child of 16 or younger is competent to consent to medical examination or treatment without the need for parental permission or knowledge.

Evidence-based care and treatment

- Care was provided to children and young people in accordance with national guidance, including guidance from the National Institute for Health and Care Excellence (NICE) and the Royal College of Paediatrics and Child Health (RCPH)Policies are based on NICE/ Royal College guidelines but although evidence was seen of recent activity in reviewing policy and guidance, there was currently no updated abduction policy. Evidence was seen of a draft policy but this meant that staff were unlikely to be aware of this trust-updated policy.
- Staff had access to all guidance, policies and procedures, which were available on the trust intranet.
- Appropriate care pathways were in place for children with long term conditions e.g. asthma or diabetes.
- Local audit activity was seen with the results displayed at the entrance or at a focal point for parents within Princess Amelia. A comprehensive audit was reviewed for medical records showing improvements for 2014-15 when 61 randomised records were audited

Pain relief

- We examined the records of patients across level 10 for this service and observed that they used a child specific pain monitoring score. Pain scores were recorded which were then monitored by staff during observational or care rounds when further pain relief was offered.
- We spoke with four children and six relatives and all confirmed that pain relief was managed and monitored to promote successful pain management.
- Four staff confirmed that they had no difficulties when requesting further pain relief prescriptions for children.
- We saw an outstanding diversional therapy approach for children and young people, which was led by the play specialist and school tutor.
- The schoolroom provided an area for children to receive schooling, listen to recitals and additional diversional therapy to overcome hospitalisation.

Nutrition and hydration

- Children spoken to by the inspectors stated that they enjoyed the food offered.
- Dietician support was accessed as required. The dietician was easily accessible and recorded in the children's notes with reviews updated as completed. .
- Fluids offered were documented on the children's fluid input chart.
- Weights of children were monitored with clear care plans of how the service would meet the needs of the child.
- The patient led assessment in a clinical environment (PLACE) was scored at 92% for food, which is above the England average of 90% PLACE inspection results reflected the introduction of steamplicity with a separate children's menu children; parents concurred that the food was good

Patient outcomes

- The CQC reviews the information provided by trusts to assess if the service has a higher mortality rate for patients with different conditions. These are called outliers if they are outside of the national rates. There are no open CQC outliers for this service.
- The median length of stay was mixed with one indicator below the England average, one above the England average and two the same (June 2015).
- The rate of multiple emergency admissions within 12 months for epilepsy was higher than the England average.
- The proportion with HbA1c is lower than 7.5%, which is lower than the England average. Median HbA1c levels for patients are higher.
- This hospital recently participated in the national clinical audit for "the initial management of the fitting

child". The Royal College of Emergency Medicine (RCEM) standards were met, except for standard four in which 0% was given as there was no written information for the child or parents.

- Paediatric asthma audits performance had been developed this year in line with the commissioners and an agreed CQUIN scheme seven to reduce the proportion of avoidable emergency admissions to hospital, which improves care for children with asthma. This project will develop community led specialist services for children with asthma and is supported by acute clinicians and expert general practitioners. The programme is on track to meet quarter one requirements. This programme has included setting up educational programmes for staff, children and parents with the support of an asthma specialist nurse in accident and emergency department. .
- The paediatric diabetes audit performance report was not received.
- The emergency readmission rates within 2 days of discharge is better than the England average for non-elective and elective admissions.
- The record keeping audit submitted showed that 48% of patients are not seen by a consultant within the first 24 hours following admission. This data is currently not comparable through information held by CQC analysts.

Competent staff

- Across children's services, 85% of staff had received an appraisal within the last year We spoke with the matron who confirmed there was a clear plan to complete the remaining staff appraisals except for those who remained on maternity or sick leave.
- Supervisory sessions were held with staff but we were not assured that these were prioritised with the current high level of agency and bank staff.
- Throughout this service, revalidation for nursing staff in line with Nursing and Midwifery Council requirements is supported by senior staff.
- Revalidation for all medical staff had been undertaken for 100% of medical staff. The clinical director confirmed that dates have been set for any outstanding appraisals

Multidisciplinary working

- Multidisciplinary meetings were held weekly. Staff were motivated and passionate about providing children and young people with a good patient experience as the service changed.
- We observed that staff across this service worked effectively together and with the children's community services.
- We observed the handover of the care of a child with multidisciplinary discussions and care pathways completed. The communications observed between doctor and nurse was professional and followed the SBAR style.
- Care and treatment plans were completed and discussed with children and their parents.
- Staff we spoke to confirmed there were good working relationships between themselves and other professionals.
- We observed a presentation from a study day promoting the work of the transition to adult services. We were informed that there was no flagging system to identify any children or young person admitted to an adult ward. Senior staff spoke regularly with the operational site team to confirm admissions The service had no updated policy for the transition of children into adult services.
- Access to psychiatric and psychology services was available through the child and adolescent mental health services (CAMHS). We were informed of examples of when these services had been used and staff reported a good working relationship with these teams. The quiet room identified for interviewing children on Princess Amelia was well situated but had no call bell facility if a staff member needed to summon assistance.

Seven-day services

- The level 10 children's service has consultant ward rounds seven days a week and the consultants were available outside of normal working hours through the on call weekend rota and on call system.
- The pharmacy department was open Monday to Friday, with on call arrangements for weekends and outside normal hours on weekdays.
- The support services for this service e.g. imaging services, occupational therapy and physiotherapy were available Monday to Friday, with out of hours arrangements supported by an on call system.
- The trust wide spiritual care and chaplaincy team were available for pastoral support for children, their families and staff. This service was available 24 hours a day, 7 days a week via an on call system.

Access to information

- Staff had access to all main computers, including test results, diagnostics and patient record systems.
- Procedures were all available through the intranet and there computer points across the service to support staff.

Consent

- Staff we interviewed were aware of the guidance with obtaining consent and the Gillick competence Staff were able to demonstrate a good understanding of the Gillick competency and children were supported to make decisions where appropriate.
- Parents were also supported to make decisions where appropriate and offered information to make best interest decisions for their child in respect of treatment.
- Parents were seen to be involved in the decision-making processes regarding care. Leaflets were available for parents who were making decisions about providing consent to surgery.

Are services for children and young people caring?

Good

The services for children and young people are rated as good. Feedback from all family members and children we spoke with during the inspection were positive about how the care was provided. The parents stated that the staff went beyond what they expected them to do for their children.

We observed good interactions between staff and children during our inspection. Staff showed respect protecting children and young people's dignity and privacy across the service. Children appeared to get on well with staff members when we observed them interacting with them during the inspection.

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

Children and their parents were active partners in their care.

Compassionate care

- We observed all areas of the children and young people's service, listened to groups of staff and individuals who were involved in patient care and found that staff responded appropriately and supported them to meet their needs.
- We saw good interactions between staff, children and families.
- All parents we spoke with during the inspection told us that they had been treated with respect and dignity by the staff.
- The following comments were collated: "All staff are friendly; neat and clean helpful staff and polite natured; its good care; friendly attentive staff who made me feel welcome; staff went beyond what I expected when caring for my child".
- The CQC undertook a children's survey in 2014. We asked children and young people, their parents and carers, to answer questions about different aspects of their care and treatment. The trust scored about the same as other trusts in relation to C1. "Are people treated with kindness, dignity, respect and compassion while they receive care and treatment?"
- We saw patient feedback information on the care of children and young people through the NHS Choices patient forum. Comments were mostly positive but, there was no acknowledgement or response from the hospital to these comments.
- Friends and Family Test results seen for April 2015 showed the following scores for patient's or parents that would recommend this hospital: Charlie Chaplin's ward 91%, Princess Amelia day-care 100% and children's outpatients 95%.
- The rate of compliments received by the service demonstrated that children and young people and their families thought that the care was good.
- Thank you cards were seen on the boards in ward areas and staff described informal thanks had been received from grateful families.
- Children's stories about their experience of care were displayed on the ward for other children and families to read, which was positive.

Understanding and involvement of patients and those close to them

- The play specialists in this service were outstanding and demonstrated how they could make a difference to the service and its environment in meeting the needs of the children and young people. We saw examples of

diversional therapy sessions, papier-mâché sculpting, heard about recitals and across the ward, posters were designed for everyone to view the life and hobbies of the original Princess Amelia
- Parents we spoke with told us that they were informed about their care and could ask any questions of the doctors or nurses

Emotional support

- Staff gave examples of how they were able to access support and training they received for breaking bad news.
- Clinical nurses for children specialities including oncology and learning disabilities supported staff, children and families when required.
- We saw evidence of teaching at the bedside for those children who could not access the school room. The teacher was very experienced and long term patients were well known to her.
- Assessments for anxiety were completed as part of the admission process within this service.
- The trust counselling services could be accessed as requested during the working week Monday to Friday.
- The trust wide spiritual care and chaplaincy team were available for pastoral support for children, their families and staff. This was available 24 hours a day via an on-call system.
- Schwartz rounds commenced in the trust eight months ago and senior staff from this service had attended. There was no evidence of paediatric cases discussed

Are services for children and young people responsive?

Requires improvement

The responsiveness for children and young people's service required improvement. The service was not always planned to be responsive to meeting the needs of children and young people with excessive waiting times. The service was achieving 73% of patients being seen within 18 weeks of referral for treatment.

The transitional arrangements for moving a child from children's care into young adult care before moving into adult care services was identified as an area for further development as not all pathways of care for long-term conditions, including those for epilepsy, were clear. There were identified gaps in management resources for this area.We saw no policy for transition from child to adult care.

The multiple admission rate for children was 48%, which was above the England average (17.4%).

The facilities available to families enabled them to stay and met their needs when supporting their children.

The children had indoor and outdoor play areas. The outdoor play area needed a refresh as it looked tired with broken storage boxes and water leaks around the area.

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

Service planning and delivery to meet the needs of local people

- The shaping a healthier future (SaHF) programme identified the removal of children's inpatient and children's emergency department from this hospital from June 2016.A general practitioners paediatric support service is to be introduced on this site.This support service will also promote the out of hospital service.
- The post surgery recovery area environment was not suitably planned and arranged for the needs of children. Children were recovered in the same area as adults as there was no dedicated paediatric area.
- There was a range of leaflets available in ward and clinic areas.

Access and flow

- Thirty-nine of the elective admissions (28%) among children in the under two year age group and 101 (72%) of the elective admissions in the above two year to 17 age group had a length of stay of one day.
- The multiple admission rate for children was 48%, which was above the England average (17.4%).
- Bed occupancy was 85% with admissions to children's ward between April and July 2015. Cases totalled was evidenced as 859 but there were two gaps in the data received.

Services for children and young people

- Ambulatory care service was through the Princess Amelia day care unit. There was a waiting area and side rooms. This service was being reviewed in line with service changes in June 2016.
- Children who attend the hospital in an emergency were seen in the children's emergency department where if, after being seen by a specialist doctor and they required admission, would be transferred to the children's ward as soon as possible for specialist care.
- Children's outpatients department dashboard showed total new outpatient activity as 669-978 between April and August 2015. In the same period do not attends (DNA's) were between 101-238 each month which gives a 12-23% DNA rate for new cases.
- The total outpatient activity follow up rate is 499-738 patients each month.
- The service was achieving 73% of patients being seen within 18 weeks of referral for treatment. 7% of patients breached over 18 weeks since Jun 2015.

Meeting people's individual needs

- The service had access to a 24-hour translation service through "language line" and in-house interpreters. Staff were aware how to access this service when required.
- Child and adolescent mental health services (CAMHS) were available through the local mental health trust. We were informed that this service would respond to the needs of the child and worked well.
- There was specialist support for caring for children with complex which includes diabetes, asthma and epilepsy. There was an identified Clinical Nurse Specialist for learning disabilities and staff were aware how to access additional resources e.g. loop system or audio books.
- We found posters across the service in English but none in other languages although leaflets were available in several languages.
- There was a schoolroom available on level 10 with a variety of diversional therapy as well as schooling support
- The play specialist supported staff working with the team to support children and young people.
- Within Charlie Chaplin ward area, there was a secure outdoor play area and a conservatory room for children to play indoors.
- There was an area for adolescents within the ward, which would meet the needs of the individual with game consoles and a television
- We saw DVDs and electronic games as well as board games to meet the varied needs of this service. We saw toys, books and other items for children to use during their stay in hospital.
- Parents of children were able to stay on the ward near the child to support them and we saw a bed chair in use.
- There were side rooms where private conversations could take place away from the main ward environment to ensure privacy was maintained.

Learning from complaints and concerns

- The trust provided a 'listening, responding and improving your experience' leaflet which was seen in a variety of languages. This leaflet details the patient advocacy and liaison service (PALS). However the 'How to make a complaint' leaflet was seen across the service but only in English. On the last page of the leaflet it does refer to three alternative translation options: large print, audio or Braille
- Posters and leaflets were displayed across the area informing parents how to make a complaint.
- Any complaints received were displayed on the ward safety board, which was situated at the end of the ward on Princess Amelia and at the entrance of the Charlie Chaplin ward and showed no complaints for this year. The board also included a 'you said, we did', which demonstrated how the staff listen to the feedback from the Friends and Family Test or complaints.
- The service had received no complaints over the past twelve months but had received five written compliments.

Are services for children and young people well-led?

Good

The services for children and young people we rated as good for well-led.

We saw areas supported by good local leadership. Governance arrangements were developed and performance monitored. We saw some escalation of assurance and concerns from ward to the board level.

A children and young people's risk register was in use and monitored at the monthly clinical governance meetings.

Services for children and young people

Communication and multidisciplinary working between medical and nursing staff was effective.

The children's senior staff communicated well with staff across the hospital and attended site operational meetings. Children's experiences were seen as the main priority.

However, we found no current Control of Substance Hazardous to Health (COSHH) assessments that followed the trust wide process.

Vision and strategy for this service

- The trust had developed a strategy, which focused on quality improvements across the integrated healthcare setting. Four of the eight staff inspectors spoke with told us they were aware of the local strategy for the directorate but not the trust wide strategy.
- The philosophy of the service was to provide safe, high quality patient centred care for children and young people through integrated care across community and acute settings.
- The trust merger had provided an opportunity for children and young people's services to be reconfigured. There was evidence of integrated working between staff but evidence that policies and information technology (I.T.) systems still remained separate between the two sites.
- There had been recent changes within the hospital, with six staff members expressing concerns about an unsettled future with uncertainty also around dates when any changes might occur.
- Senior nursing staff working in specific roles, such as clinical specialist nurses were aware of the vision and strategy for their own specialisms.
- There was inconsistency of staff awareness of the trust values.

Governance, risk management and quality measurement

- There were daily handover and ward meetings as well as safeguarding meetings. Clinical governance issues for assurance and escalation were then reported into the monthly directorate clinical governance meeting. Ward meetings were held monthly around patient activity and we saw minutes from the last meeting.
- A children and young people's risk register was in use and monitored at the monthly clinical governance meetings. These risks were escalated to the trust board. Incidents were reviewed weekly to improve safety, reduce risk and ensure lessons were learned. Lessons learned were not seen on the incident list provided by the trust.
- There was evidence of incident reporting and audit, with identified themes and trends.
- Risk and governance folders were reviewed on the ward. This meant staff could access the latest information about clinical incidents.
- The service used a quality dashboard that was reviewed monthly at this service's governance meeting, which escalated any concerns to the trust wide governance committee.
- The children's directorate risk register and meeting minutes were reviewed by us and was found to identify risks related to: clinical quality of care, governance, estates, workforce, strategic change and finance. Risks were scored from initial rating to a target rating and the current rating. A colour code was applied to indicate level of risk, using green, amber up to a red risk rating.
- Staff training, including risk awareness was evidenced through the education and learning management database(ELMS).
- Inspectors saw that not all parts of this service governance worked effectively. Senior staff were not aware of trust wide changes for Control of Substance Hazardous to Health (COSHH). The COSHH assessments were checked by inspectors and were significantly out of date. Senior staff confirmed that all registers for this service would be reviewed.
- A "Risk news" information newsletter provided staff with feedback and shared lessons learned across the trust.
- We asked for but were not provided with the numbers of staff that had completed root cause analysis training.

Leadership of service

- The majority of staff reported being well supported and told us senior staff would listen and respond when they raised issues or concerns but that they were concerned about their future.
- Eight staff told us that the senior team was approachable. However staff reported that managers were not as visible since the trust as most managers were now based at Northwick Park.r
- The clinical directorate leadership was widely supported by all staff interviewed.

Culture within the service

- Staff described the service's culture as being open and supportive but identified gaps in the integrated healthcare service.
- Staff stated they would be able to raise concerns without fear of reprisal although one staff raised concerns about the approachability of her line manager.
- Staff were willing to speak openly and they informed the inspectors that their managers listened to them when they raised concerns.
- We saw multidisciplinary working with frequent meetings to support staff and sustain high quality patient centred care.
- The junior doctors we spoke to confirmed that consultants were supportive and described a structured training programme.

Public and staff engagement

- Patients and their families were encouraged to engage with the service.
- Friends and Family Tests were used and results indicated that 95% of children and parents would recommend this service.
- Children were encouraged to share their experience through the sessions with the play specialist.
- Staff were encouraged to develop professionally and one healthcare assistant informed us of her career progression to nurse training. This was supported by her line manager and the trust.
- We spoke to eight staff who reported positively on the level of engagement with their manager.
- Overseas nurses were supported to develop at this trust. The trust was working with a local university to support overseas nurses with additional qualifications so that they progress in their careers.
- One student nurse stated that they wanted to work at this trust when they completed their studies and were qualified, due to the support received whilst on placement.
- The "Our Trust" magazine issue three for winter 2015 celebrated staff successes and the integrated trust first anniversary.

Innovation, improvement and sustainability

- Development of the rapid access clinic, which is a general practitioners (GPs) paediatric, support service. This improvement in service provides crisis care for children across the community. Children referred by their GP are given a same day or next day appointment and prevent accident and emergency attendance.
- The play specialist supported children and young people to create drawings, clay models and poster displays across Princess Amelia, which describes the background of this local historical figure, whom the ward was named after
- Senior staff discussed the innovation of the Ealing Services for Children with Additional Needs (ESCAN) - multi-agency hub of services.
- We were informed that 'Schwartz' rounds commenced in the trust eight months ago senior staff had attended but no evidence of paediatric cases discussed. Schwartz rounds are meetings which provide an opportunity for staff from all disciplines across the organisation to reflect on the emotional aspects of their work. Senior staff informed us of the trust introducing the Schwartz rounds with representation from this service.
- We were informed of the use of "optiflow" (High flow nasal cannula therapy for adults adolescents and children more than 8 years) to support HDU cases on the non-HDU ward.

End of life care

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

Information about the service

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

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

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

The specialist palliative care team (SPCT) for Ealing Hospital is made up of two clinical nurse specialist (CNS) and consultant support based at Meadow House Hospice, which is located on site at Ealing Hospital.

The SPCT provided specialist support for people facing serious illness which was usually complex. Patients who did not have complex serious illness or potentially complicated deaths were supported by other generalist or speciality doctors and nurses on the ward the patient was admitted to; the SPCT was available to give support and guidance to staff about these patients if they required it. During the period 4 January to 29 September 2015 there were 356 patients referred to the SPCT of which 53% had a cancer diagnosis and 47% had a non-cancer diagnosis. The team on average received 500 referrals per year.

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

The SPCT was available Monday to Friday from 8am to 4pm and out of hours on-call cover was available to clinicians.

We spoke with 12 members of staff; which included local level service leads for specialist palliative care and end of life care, ward nurses, allied health professionals, clinical nurse specialists in palliative care and consultants, administration staff, porters, staff in the bereavement office and mortuary and a chaplain.

We observed staff interactions with patients and those close to them and spoke with two patients and two relatives. We reviewed five care records and eight do not

attempt cardio pulmonary resuscitation (DNACPR) records. We also reviewed thank you cards and letters. During and prior to the inspection we requested a large amount of data in relation to the service which we also reviewed.

Summary of findings

We rated the end of life care services at Ealing Hospital as 'requiring improvement' overall. We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner. They were hard working and supported the ward-based teams on a daily basis.

We saw that staff considered cultural differences when discussing death and dying and only took the conversations as far as the family were comfortable. However, less experienced staff could use this as a reason not to discuss a patient's prognosis which meant some patients and families may not know what resources are available to them at the end of life. The mortuary and bereavement staff were aware that different cultures had different needs when caring for patients and families after death.

The patients and relatives spoke positively about their interactions with the teams involved in their care. They described the staff as "considerate and thoughtful" and "caring and kind". They told us they were understood and able to raise any concerns they had. One compliment letter said "the doctor's sensitivity and with high integrity educated us to the gravity of our relative's condition."

The trust had responded to the withdrawal of the Liverpool Care Pathway, which had previously been seen as best practice when someone reached the last days and hours of life. The trust used a holistic document which was in line with the five priorities of care. This care plan, called the 'Last Days of Life Care Agreement' (LDLCA), guided staff to consider and discuss the patient's physical, emotional, spiritual, psychological and social needs. The LDLCA also took into account the views of those important to the patient and provided them with an information leaflet about what happens when someone is dying, and what to expect.

As part of the LDLCA, the patient's pain relief, symptom management and nutrition and hydration needs were monitored and recorded at regular intervals during the day. Patients' records and care plans were regularly

updated; matched the needs of the patient, and were relevant to EOLC. The LDLCA reminded staff that they should remain open to the possibility of changing the plan should a patient's clinical condition change. This included withdrawing the LDLCA if the patients did not deteriorate at the expected rate and it was no longer appropriate for it to be used. The LDLCA was not being used for any of the patients we reviewed, although 'do not attempt cardio pulmonary resuscitation' orders were in place. The completion of DNACPRs was variable. Some were not fully completed or discussed or signed off by a senior clinician.

The SPCT leads were focussed on raising staff awareness around EOLC. However they said that this should be a trust wide responsibility as "death and dying is everyone's business" and the onus should not be placed solely on the SPCT to take forward. The trust had recently secured funding to develop an e-learning package for all staff to complete.

There were some concerns raised by specialist staff about whether all generalist nurses, doctors and consultants had the expertise to recognise patients who were dying; and had the skills to have difficult conversations about planning care for those at the end of their life.

Staff were aware of their responsibility in raising concerns and reporting incidents. However, we found there was apathy in reporting everything including near misses due to a lack of feedback and learning outcomes.

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

The SPCT leads reported a better emphasis on EOLC at board level over the last year. However, they said that they were still the key driver for improving staff engagement, training and skills. The SPCT at Ealing hospital did not feel engaged with the trust strategy and were unsure how it would affect services at Ealing Hospital. While they were listened to by the service leads they did not feel they were unsure of their influence trust wide.

End of life care

Are end of life care services safe?

Good

Safety across Ealing Hospital for end of life care was good. All staff received mandatory training and the SPCT had achieved 100% compliance in most subjects. Safeguarding vulnerable adults, children and young people was given sufficient priority. Staff were able to communicate their responsibility and role in early identification of any concerns. They know whom the safeguarding lead for the trust was and where to get guidance should they require it.

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

Where staff used the 'Last Days of Life Care Agreement' (LDLCA) document to plan holistic care and support for the dying patient, the record was clear. Staff spoke positively about this record as it guided them through everything they should consider and discuss with the patient and those close to them. However this document was not compulsory to use and where it was not used we found that records were difficult to navigate. Conversations and agreed treatment and care options were scattered throughout the patient's record and did not give a clear picture without reading back through notes.

Openness and transparency about safety was encouraged. Staff fully understood their responsibility to raise their concerns and report incident and near misses. However, we found apathy amongst some staff to report all incidents and near misses due to a perceived lack of feedback and learning outcomes. Those incidents that were reported were investigated adequately and learning points and actions identified in the incident reports. The SPCT supported training staff on the wards where any EOL or palliative care incident were identified. We were told that incidents relating to EOLC were shared across the hospitals in the trust.

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

Safety performance, Incident reporting, learning and improvement

- Serious incidents known as 'Never Events' are largely preventable patient safety incidents that should not occur if the available preventative measures had been implemented. End of life care (EoLC) services had not reported any never events or serious incidents in the last 12 months.
- The trust had systems in place to report and record safety incidents, near misses and allegations of abuse; and share any learning and changes to improve the safety and quality of the service. In the period form 1 July 2014 to 31 July 2015, the trust reported no incidents relating to the palliative and end of life services across the hospital. However there were incidents which related to patients who were in the end of life phase or receiving palliative care. The a majority of these were relating to the community services. There were two reported incidents relating to the mortuary; one relating to the bariatric fridge being out of service, and the other related to a deceased patient who was not identified by ward staff as having an infectious disease. The incidents were adequately investigated with all parties involved in the incident from acute and community services. A root cause analysis was completed with learning points identified.
- Staff told us they used the electronic reporting system 'Datix' to report any incidents of concern. The SPCNs told us they tried to raise any concerns with the ward manager or sister at the time of it being identified.They received confirmation that any reported incident had been received by their manager but told us they rarely received feedback on the outcome or any related learning. The SPCNs said that reporting incidents and near misses had declined due to the lack of feedback and learning.

- The Datix system allowed incident reports to be shared between Ealing and Northwick Park Hospitals. There were opportunities at joint meetings to discuss incidents that affected all services across the trust, for example those that meant a change in policy or procedure. Reminders were displayed on the trust's computer screen savers.
- Staff were trained on duty of candour as part of the risk management training at induction and the mandatory update training. The staff we spoke with understood their role and responsibility in informing patients of incidents that could or have affected them. They told us they would apologies, explain what actions have been taken as a result of the situation and offer support. Staff added they would support a patient in making a formal complaint if they were not satisfied with actions taken. We saw apologies made to patients and carers was documented in patient records and on Datix.

Cleanliness, infection control and hygiene

- We found the trust had systems in place to prevent and protect people from healthcare associated infections. The trust had an infection prevention and control policy (IPC) and all staff received training. The staff we spoke with had a good understanding of IPC practices and we observed staff following IPC measures when visiting the patients on the wards. Staff were aware of patients' reduced immune systems and the measure they should take in order not to compromise their health through poor infection control.
- Infection prevention and control formed one of the mandatory training modules for staff. The SPCNs had completed this training.
- The mortuary area was spotless, tidy, smelt fresh, and clean. We observed strict hand hygiene measures and visitors to the mortuary area were reminded of the importance of cleansing their hands prior to leaving the premises.
- Deceased patients who had an infectious disease were identified by a wristband and placed in a body bag. A high-risk identification sticker was attached to the bag once they arrived at the mortuary, where they were placed in a separate fridge. Any visitors for the deceased were advised not to touch the body and the undertakers were informed for their own protection when they collected the body. However the nature of the infection was not disclosed unless necessary. Personal protective equipment such as gloves or aprons were provided to undertakers if required.

Environment and equipment

- The trust used T34 syringe drivers, which were all of a standardised type that conformed to national safety guidelines on the use of continuous subcutaneous infusions of analgesia.
- Each ward was encouraged to take responsibility of getting and returning syringe drivers to the store at the hospital. Any issues in relation to the use of care of syringe drivers was reported on Datix.
- The trust had responsibility for maintaining all the syringe drivers. We were told there were no problems in accessing syringe drivers whenever they were needed for patients.
- The mortuary manager had put in place many processes to ensure that the deceased was kept in the best condition as possible. Fridge temperatures were checked daily and any concerns reported immediately. Systems were in place to ensure the correct identity of the deceased person including measures for patients with similar names. We observed a tight checking system when undertakers came to transfer a body.
- All the equipment such as trolleys, cleaning equipment and personal protective equipment was clean and stored in a tidy manner. No post mortems took place at the hospital. There was a male and female changing room available for the mortuary technician.
- A viewing room provided families or friends a private quiet space should they wish to spend time with the deceased. We found this and the waiting area was clean and tidy. Deceased children and babies were laid out in a smaller bed or a Moses basket.

Medicines management

- There were arrangements in place to keep people safe and manage medicines for patients. Medicine management formed one of the mandatory training modules for staff. Training records showed that one of the SPCN's medicine management training had expired. We were unable to tell if the other SPCN had completed their training, as the record we received from the trust was incomplete.

- As part of the patients' holistic assessment, symptom control and medication was monitored and reviewed by a SPCN and any changes were discussed with the consultant responsible for their care and the ward staff. This was documented in the patient record.
- Patients who expressed a wish to die at home were discharged from the acute hospital with anticipatory injectable medication and medication record charts. These were provided to patients whose condition may require the use of injectable medication to control unpleasant symptoms if they were unable to take oral medication due to their deteriorating condition. Having anticipatory drugs available in the home allowed qualified staff to attend and administer drugs, which may stabilise a patient or reduce pain and anxiety and prevent the need for an emergency admission to hospital.
- Where appropriate patients had syringe drivers which delivered measured doses of drugs over 24 hours. They could be discharged from hospital with a syringe driver in place however this needed to be changed to a syringe driver from the community resources as soon as practicable and the hospital driver returned.
- The syringe drivers were locked as per guidelines to prevent other people altering or increasing doses.
- We noted that medication administration records were completed correctly and signed. We found the prescribers' names were not always clearly printed on the medication administration records although they were always signed, this could make it hard to find the prescriber if anyone needed to discuss the prescribed drugs.
- There was not specialist palliative pharmacy support available for staff. However they could get advice and support from the hospital's pharmacist.

Quality of records

- People's individual records were written and managed in a way that kept them safe. Records reviewed were accurate, legible, and up to date and stored securely.
- Patients' palliative care needs, care plan and resuscitation status was entered onto a system called 'Coordinate my Care' (CmC). CmC is a shared clinical service which allows healthcare professionals to record a patient's wishes and ensures their personalised care plan is available for all those who care for them, including ambulance and community services. This means the patient receives the most appropriate care and treatment and prevents unnecessary hospital admissions.

Safeguarding

- Staff understood their role with regard to keeping patients' safe and reporting any issues. This included identifying any risks to the patient's family such as children or vulnerable adults whose main carer may be the patient.
- All staff complete training about safeguarding children and vulnerable adults as part of their mandatory training modules. Staff we spoke with demonstrated an awareness of safeguarding procedures and how to recognise if someone was at risk or had been exposed to abuse. Staff told us if they had any concerns they would speak to the trust safeguarding lead or their manager, and knew where to access the trust policy on the intranet.
- Staff safeguarding level 1 and 2 training for adults was part of mandatory training and was routinely provided to all staff. Similarly safeguarding children level 1 training was provided to nearly all staff including administrative and clerical staff. Safeguarding children level 2 was mandatory for all nurses and allied health professionals. The SPCT had achieved 100% compliance in safeguarding children level one and two; and 100% compliance in safeguarding adults' level 2.

Mandatory training

- All staff took part in mandatory and statutory training to ensure they were trained in safety systems, process and practices such as basic life support, conflict resolution, fire safety, infection control and health and safety.
- Many of the mandatory training modules were accessed thought the trust's online training system called ELMS. Staff reported positively about this system as they could track their own training and received reminders when it was due for renewal. Their manager also received reminders so that they could ensure all their team had completed their training. Many of the training modules were through online teaching sessions. However some modules such as basic life support were still completed in a practical face-to-face session.
- All staff from the SPCT told us they had completed their mandatory training or were due to complete it in the

next few weeks. Records showed the SPCT had reached 100% compliance in 13 out of 15 subjects. One member of staff was no longer compliant in medicines management and diabetes management in hospital.

- The mortuary staff and porters received mandatory training. Mortuary staff were 100% compliant. The porters had not achieved the trust's compliance level of 80% in some subjects. The training matrix for September 2015 showed 71% compliance in infection prevention and control, 60% in safeguarding and 62% in manual handling.

Assessing and responding to patient risk

- We found that patients supported by the SPCNs were regularly assessed and any changes in the patient were identified quickly. Care plans were updated and discussed with the nursing team caring for the patient day-to-day.
- We found a mixed response in how well the nurses on the wards recognised a patient was approaching the last 12 months or less of life. Some of the SPCNs had concerns whether generalist nurses always had the experience to recognise a patient who was deteriorating and reaching the end of their life. They told us they did not think that staff knew the difference between specialist palliative care and EOLC. This varied recognition could mean some patients would not receive appropriate support and in the way they would like it, as there was a lost opportunity to discuss advanced care plans in the last 12 months or less of their life.
- Most of the staff we spoke with in on the wards were aware they could access advice and request specialist support from the SPCT if their patient had been identified as requiring palliative or EOL support. However the SPCNs were concerned that they would not request the support if they did not have the necessary skills to recognise that a patient had deteriorated in the first place.
- At the end of life, there are inevitable changes to the body such as weight and skin integrity. Staff used tools to assess risks to patients, such as a pressure damage risk assessment to identify and prevent pressure ulcers. We saw the assessments were completed fully on the trust's electronic patient record system. Appropriate pressure relief mattresses and advice on how to reduce the risk of pressure trauma and maintain healthy skin was provided to patients assessed at risk.

Nursing staffing

- National commissioning guidance suggests the minimum requirement for specialist palliative care nurses (SPCN) is one SPCN per 250 beds. Ealing Hospital has approximately 358 beds. The SPCT was made up of two whole time equivalent (WTE) band 7 clinical nurse specialists (CNS).
- The trust's lead nurse for cancer and palliative care visited the Ealing team twice per week. They line managed 24.7WTE staff (this included the Macmillan clinical nursing specialists).Funding for a matron post to concentrate purely on palliative and EOLC across the trust had recently been applied for.

Medical staffing

- Commissioning guidance suggests the minimum requirement for consultants in palliative medicine is one WTE per 250 beds. One consultant based at Meadow House Hospice (MHH) which was based in the hospital's ground provided one session per week at the hospital. They and the other consultants at MHH were reported to be flexible and would come to the hospital at any time if required. However, the arranged consultant cover did not appear to be sufficient according to commissioning guidance.

Are end of life care services effective?

Requires improvement

We rated effectiveness of end of life care as requires improvement.

There were concerns some ward nurses and doctors lacked the expertise or experience to recognise when a patient was in the last 12 months or less of their life; or was rapidly deteriorating due to being at end of life, especially if they were frail and elderly.

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

End of life care was managed in accordance with national guidelines.

End of life care

The SPCT (specialist palliative care team) was made up of a highly skilled and knowledgeable staff group who supported patients with palliative care and end of life patients with complex health needs. The CNSs provided effective support and advice to staff supporting patients with palliative or end of life needs.

The trust had responded to the phasing out of the 'Liverpool Care Pathway' with a holistic care plan called the 'Last Days of Life Care Agreement' (LDLCA). This document was not compulsory to use although all staff were expected to consider the five priorities of care which took into account a patient's wishes, and emotional, psychological and spiritual needs. We saw the LDLCA was fully completed for those patients who had one; the plan of care and reasons behind the decisions was clearly documented.

Ealing Hospital's SPCT had in the past provided EOLC and palliative care training at induction. However this had been discontinued since the merger of the hospitals and had created a gap in staff's knowledge. The trust had identified the need for all staff to complete a training module in end of life care and recognising dying. The trust had recently approved funding to develop an e-learning package for all staff to complete.

Ealing Hospital routinely collected and monitored information against key performance indicators to measure the outcome of people's care and treatment. The hospital took part in national and a minimal number of local audits. The service level leads expressed the need to collect more complex information to understand patient outcomes and improve on services across the whole trust.

Evidence-based care and treatment

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

as a variance. Referring to the LCP could cause patients and families concern that they are on the 'pathway to death' due to the adverse attention the LCP received culminating in its eventual phasing out.

Pain relief

- We found anticipatory prescribing followed the new draft NICE guidelines for symptom control. Some pain control was managed with PRN ('pro re nata' / as required) paracetemol. Patients told us they had received pain relief and their pain was dealt with effectively.
- The SPCT's consultants and nurses were experts in their field and able to provide guidance on the most effective and appropriate treatments and care at end of life, which included pain relief, nausea and vomiting.
- Where appropriate patients had syringe drivers which delivered measured doses of drugs over 24 hours. All qualified nursing staff were trained in using syringe drivers and symptom management.
- The CNSs were not trained as prescribers. However they told us the doctors were usually good at taking their advice regarding symptom control and pain management and prescribed in a timely manner. Each ward had a pharmacist and they could dispense the drugs quickly.

Nutrition and hydration

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

Patient outcomes

- Ealing Hospital routinely collected and monitored information about the outcome of people's care and treatment. The key performance indicators (KPIs) included how many patients had a preferred place of death; recorded the number who achieved their preferred place and ethnicity. Measuring outcomes allowed the team to monitor their targets and drive up improvement if required.
- The trust participated in the National Care of the Dying Audit – Hospitals (NCDAH). The audit was made up of an organisational assessment and a clinical audit. Ealing hospital had achieved four out of seven key performance indicators (KPI) in the organisational audit and three out of ten KPIs for the clinical audit. Clinical audit revealed gaps in the following KPIs:
  - MDT recognition of dying
  - Discussions with patients and families in preparation for death
  - Communication of plans to patients and families
  - Assessments of patient and family spiritual needs
  - Discussions regarding provision of nutrition and hydration during the dying phase
  - Medication prescription for the 5 key symptoms of dying
  - Regular review of the patient during the dying process

The SPCT had analysed the main findings of the audit and had proposed a number of recommendations to improve the services, such as improving recognition of approaching death. The action plan clearly outlined the recommendation, progress and completion dates.

- The hospital had submitted data for the most recent NCDAH and the results were due in May 2016 this would show whether improvements had been made since the last audit.
- The hospital provided data to Public Health England's 'Minimum Data Sets (MDS) for Palliative Care'. The aim of the MDS is to provide good quality, comprehensive data about hospice and specialist palliative care services on a continuing basis. The data is useful for service

management, monitoring and audit, development of strategy and service planning, commissioning of services and development of national policy. The trust had very recently received the results for 2014/15, and they were currently reviewing how they performed against other organisations of a similar size to them at a national and local level.

- The trust took part in the 'London Cancer Alliance Palliative Care Audit'. This showed how the hospitals and hospice performed against other providers across London. The comparison of numbers of individuals seen by Ealing Hospital had seen a small decrease from 445 in 2011-2012, to 431 in 2013-2014. The average across London was an increase of 6.1%.
- The hospital took part in the bereavement audit (this is an optional part of the NCDAH). They were in line or better than the results from National Survey of Bereaved People (VOICES) 2014.

Competent staff

- The SPCTs were made up of competent and highly trained individuals. A majority of staff reported having the opportunity to develop and attend further education courses in line with their role. Although at times workload meant they were unable to attend as many courses or conferences as they would like to.
- Staff had regular one to one meetings and clinical supervision where they could discuss concerns and any cases they had found emotionally difficult.
- Prior to the trust merger with Northwick Park and Central Middlesex Hospital's the team had run regular EOLC and palliative care induction training for all staff. However since the merger it had been stopped and the CNSs expressed a concern that recognition of the dying patient was patchy. They also said that junior staff did not know the difference between EOL and palliative care and the support the SPCT could give.
- There was some concern that doctors did not always have the skills or expertise to recognise when a patient was not going to recover from their illness or in the last 12 months of life or less, and therefore did not consider discussing advanced care planning. The lack of recognition could also lead a patient to receive treatment and undertake observations that was no longer beneficial to them.
- The SPCT provided support and training at the bedside to generalist staff. The CNSs visited each ward in the hospital every day to identify any help the staff and patients may need.
- Generalist and specialist nurses and doctors who regularly supported patients at the EOL could take a secondment opportunity at Meadow House Hospice in order to gain further confidence and expertise in supporting patients who had life limiting illnesses or were at the end of their life.
- Sage and Thyme ® communication training was available to all staff in the trust, including administrative staff. This training was designed to train all grades of staff in how to listen and respond to patients/clients or carers who are distressed or concerned. Staff who had undertaken this training spoke positively about it as they were more confident in having a conversation with someone who was distressed or concerned.
- The palliative medicine consultants and SPCNs took advanced communications skills training so that they could support patients and families through difficult conversations and breaking bad news. Both of the CNSs had completed this training.
- Porters were employed by a private company who trained them in EOLC for the deceased. This included treating the body with dignity and respect, how to transfer bodies from the ward to mortuary, and mortuary procedures.

Multidisciplinary working

- Each of the CNSs held their own caseload of patients. However the two team members spoke every day and had a more formal discussion each week about their patients.
- A member of the SPCT aimed to attend ward multidisciplinary team (MDT) meetings, especially on wards where patients were likely to be identified as requiring palliative or EOLC. We observed on MDT which was made up of a first year doctor, psychiatrist, social worker, discharge lead, dietician, ward manager, physiotherapist, occupational therapist and CNS. The multi-professional team identified extra support the patient required, such as clinical expertise or social or psychological support. We observed the team assess and plan on-going care, which included moves between teams or services such as discharge to a community or home setting.

- The team discussed care plans, which were individualised and based on the patient's wishes and needs. We witnessed staff of all levels were clear and open challenge between each other, relevant questions were asked to draw conclusions.
- There were clear pathways between the hospital and community settings to facilitate patients being discharged (if safe to do so) to home, hospice or care/ nursing home.

Seven-day services

- The SPCT provided face-to-face support from 8am to 4pm Monday to Friday.
- MHH provided a 24-hour helpline for clinicians. They triaged the calls and directed the caller to the most appropriate support, such as the on-call CNS or consultant.
- The mortuary was open form 8am to 4pm Monday to Friday. Porters accessed the mortuary area outside of these hours and the mortuary manager or a regular locum was available on-call if there were any issues.

Access to information

- During September and October 2015, the trust had migrated patient electronic records from one electronic patient record system to another, with an aim for more accessibility and improved information sharing opportunities across the trust.
- Information about each patient the CNSs were supporting was held in a card box file, which both of them had access to. If there was unexpected staff absence SPCT team members from Northwich Park could access this information in their CNSs office at Ealing Hospital. They were not able to access any electronic records remotely should they need to give telephone support. However staff from MMH could visit patients in the hospital in urgent cases.
- Patients who were identified as at end of life and had an advanced care plan and/or a do not attempt cardio pulmonary resuscitation (DNACPR) were entered onto an electronic record called 'Coordinate My Care'. The patient's illness, wishes and personalised urgent care plan could be accessed by anyone involved in the their care, such as their GP, community nurses, hospital team, out-of-hours doctors, specialist nurses, and ambulance service. This allowed them to know what care they should deliver to the patient. The trust audited the number of patients entered onto CmC and 100% of those eligible to be on CmC had been included for the period between April and October 2015.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Staff undertook Mental Capacity Act (MCA) 2005 and Deprivation of Liberty Safeguards (DoLS) training as part of their mandatory equality diversity and human rights training. We gave hypothetical situations to staff and most of them were able to describe the process they would follow should someone be found to not have consent to agree to treatment or be able to make decisions in relation to their care. This included consulting with people who were close to them to gauge what the patient would have wanted in order to make best interest decisions.
- MCA and DoLS guidance was available of the trust's intranet and associated documents such as the consent policy, dementia policy and safeguarding adults at risk policy.
- The policy for consent to examination or treatment was available to staff on the trust's intranet.This was under review at the time of our inspection. We found it made reference to the Mental Capacity Act (2005). A mental capacity assessment checklist and a consent training competency proforma were included in the policy.
- Staff could access support and advice from the hospital social workers in relation to the MCA and DoLS. We spoke with one DoLS assessor who had come to the hospital to assess two patients at EOL, as they appeared to be lacking the mental capacity to consent or make decisions. The assessor told us all applications were assessed and then agreed by a mental health doctor.
- We reviewed ten do not attempt cardio pulmonary resuscitation (DNACPR) forms. We found six to be completed correctly. The level of completion for the remaining four was variable. For example, two forms had not been completed or signed by a clinician with sufficient seniority. Another patient had two DNACPR orders which created a confusing picture; and another detailed that the decision for DNACPR was in the patient's best interest due to age and dementia and did not otherwise identify the patient's illness or condition.
- DNACPR forms completed in acute settings were not transferrable with the patient to their home, care/ nursing home or hospice therefore the patient's GP was

responsible for completing a DNACPR directive as soon as possible after the patient reached their home. This ensured all interested parties fully understood the process.

- The trust-wide DNACPR audit report dated November 2015 looked at 155 DNACPR orders across the three hospital sites (Ealing [33 patients], Northwick Park [93 patients], and Central Middlesex [29 patients]). The audit identified areas of good and poor practice.
  - The audit found that in 26 cases there was no summary of communication documents with either the patient or those close to them; 46 patients had capacity to make and communicate decisions about CPR and 101 lacked capacity.There was no documentation for seven patients.
  - 150 DNACPR forms had the date of the decision recorded and 114 forms had the time of the DNACPR recorded.
  - 140 DNACPR forms had documented the grade of the doctor making the DNACPR decision, 105 of these decisions were recorded by a registrar or above grade doctor, and four forms had been completed by a Senior House Office/FY1 doctor.
  - Good practice included name, hospital/NHS number, address, DNACPR decision being recorded and the number of patients who had a capacity assessment.

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

Are end of life care services caring?

Good

The support and care given to patients identified as at the end of their life and after death was good. We spoke with one patient. Other patients had been identified for us to visit but we were advised not to visit one of them due to their circumstances and the other three had died before we could meet with them or their relatives. The patient we spoke with told us although the staff on the ward "were very kind, and had time for you even though they were very busy."

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

We observed positive interactions between staff and patients. The porters described how they always "chatted with the patients and told them what they were doing", they ensured they moved patients as quickly and gently as possible when transferring them from one location in the hospital to another, such the ward to x-ray department. The described how they transferred deceased patients from the wards maintaining maximum privacy and dignity when moving in public spaces.

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

We saw from patient records that discussions were held with patients and those close to them. However we noted in some care records that the patients or relatives views were not detailed fully, although it indicated the discussion had taken place. Therefore, we were unable to ascertain what was said and what the response was and any concerns or questions raised by the patient or family member.

The mortuary manager had a caring approach and considered the needs of the deceased and those close to them at all times. They aimed to fulfil family requests, such as dressing them in their own clothes, wherever possible.

Compassionate care

End of life care

- The results from the NCDAH local survey of bereaved relatives were in line with the National Survey of Bereaved People (VOICES) 2014; 66% of people thought the doctors and 70% of people thought the nurses always treated their relative with respect and dignity during the last two days of life. They scored 13 in the friends and family test with 68% of people saying they extremely likely or likely to recommend their friends of family to the hospital, while 12% were unlikely or extremely unlikely.
- We visited the wards and saw staff treated patients and their families with respect and worked hard at maintaining people's dignity. Staff sought permission to enter the patients' bed space prior to entry. We heard staff introduce themselves to any patient they had not seen them before or to remind a patient of who they were.
- We observed staff provide care and support. We noted how they took great care to explain what they were going to do and how they were going to do it, and ensure that the patient, and family if appropriate, were happy for the care to be undertaken.
- Patients and families told us they were very happy with the support they received from the nurses. One patient told us "the staff have been very good, they sorted out my pain."
- Porters and mortuary staff said that the bodies of deceased patients were handled in a compassionate way and there had not been any concerns about the condition of the bodies when they arrived in the mortuary area.
- A deceased person's possessions were kept by the bereavement office in an individual bag. This was returned to family members when they collected the death certificate. This meant they did not need to make multiple trips to the hospital unnecessarily.
- The bereavement officer told us how they built up a rapid relationship with families to support them in an individualised way. They gave them the time they needed to discuss what happens next.
- We observed the mortuary manager consider each of the deceased in an individual way. For example one family member was worried their relative would be cold and asked them to be dressed in their own warm clothes. We saw that this had been done. The mortuary staff had also created a 'deceased patient passport' where they documented conversations or social facts that were important for other staff to know if the mortuary manager was not on-duty. This information included things that were important to the patient or family, such as always having a pillow under their head or facts, such as the person being a previous member of staff at the hospital, or a staff member's relative.

Understanding and involvement of patients and those close to them

- Patients were given a named nurse on the wards. This allowed patients and those close to them to identify who was responsible for their care on a day-to-day basis. The CNSs shared the patient caseload. Both team members were aware of the patient should they need to support them in their colleague's absence.
- We found the CNSs and most of the ward nurses had a good understanding of their patients and what was important to them. They spoke about their patients in a personable and caring way. Those nurses that did not know their patients well were generally newly qualified and relied on their mentor's knowledge.
- Records showed some discussions between clinicians and patients and those close to them. In some cases the views of the family were detailed, while others only stated that the family member "agreed" with whatever had been discussed, such as DNACPR.
- One patient we spoke told us that, despite having had a conversation with the palliative care consultant on more than one occasion, they were still unaware of some of their symptoms. This was causing them major concern especially as they were going home and the symptom they had affected their life.

Emotional support

- The results from the NCDAH local survey of bereaved relatives indicated that 76% of people thought overall that they were adequately supported during the last two days of their relative's life.
- The SPCNs, ward staff and chaplain gave emotional support to patients and their relatives. Staff told us they would give them as much time as they needed to talk about their thoughts and feelings. They told us of other agencies which could offer support to the patient and those close to them, such as counselling services and spiritual/faith/religious leaders.

End of life care

- The hospitals' multi-faith chaplaincy service was available to support patients and we saw evidence of staff offering this service. Patients and families were able to arrange for their own spiritual leader to visit the hospital.
- The bereavement officer supported relatives and friends after a patient's death by explaining all the legal processes and what to expect when someone has died. An information pack which included contact details for support and counselling groups was provided.
- Emotional support extended to the clinical team through peer support and one to one clinical supervision. Staff told us they could take some time out if they found it hard to cope at any point. However, this was said to be rare as the day to day support they gave each other was usually enough.
- An annual memorial service took place for people close to a patient who had died at the hospital.
- Schwarz rounds were run for staff from all disciplines. Schwarz rounds are designed for staff to discuss emotional and social issues that have arisen in caring for patients. This allowed staff to reflect and explore the human and emotional aspects of the experience of delivering care and the challenge they face from day-to-day.

Are end of life care services responsive?

Good

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

We found the hospital SPCT liaised with staff and patients on the ward to ensure patients were supported in the way that met their individual needs. They aimed to identify a patient's discharge needs as early on as possible so that the patient received with seamless and equitable EOLC wherever they chose to be supported, thus decreasing the number of unplanned and inappropriate admissions to hospital when someone was reaching the end of their life.

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

Hospital staff referred a majority of patients who had died in the hospital to the SPCT, this included patients with cancer and non-cancer diagnosis. The SPCT regularly received an average of 500 referrals per year and support from the CNSs was provided in a timely manner.

Patients were supported in being transferred to their preferred place of death through a 24-hour rapid discharge process. The hospital collected data on how many patients had their preferred place of death recorded and how many achieved it, figures showed they achieved the set targets for this. The reasons that a patient did not die in their preferred place was recorded so any issues that did not meet an individual's pretences could be identified.

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

There were very few complaints about EOL services. All staff told us they preferred to deal with issues or complaints immediately and offered a face-to-face meeting with the complainant.

Planning and delivering services which meet people's needs

- London North West Healthcare NHS Trust was a newly merged service comprising three acute hospitals, three community in-patient units (Meadow House hospice, Willesden Hospital and the Denham Unit) and community services for three London boroughs (Ealing, Brent and Harrow). The draft EOLC strategy stated 'across this area around 100 people die each week, many of which will have a predicted death, even if only recognised in the last days or hours. Whether they

spend their final days in their own home, care home or as an in-patient, LNWHT staff have the opportunity to optimise the dying experience for both those at the end of their lives and those left behind'.

- The aim of the strategy was to ensure that all people reaching the end of their life received the most appropriate care and support for their own circumstances and avoid unnecessary hospital admissions for those that wished to be cared for outside of a hospital environment. This included providing generalist high quality EOLC which could be delivered by non-specialist health and care staff as part of their core work provided they were given education, training and support to do so.
- The hospital did not have dedicated end of life beds. Patients identified as being in the last days or hours of life were mostly cared for on general medical and surgical wards. Staff told us where possible patients were moved to a side room to offer more privacy when they were nearing the end of their life; and if this was not possible due to the number of patient on the ward and their nursing needs, curtains were drawn around their bed.
- Specialist palliative care beds could be arranged through the community SPCT at Meadow House Hospice and was dependent on the needs of the patient and not guaranteed.

Meeting people's individual needs

- We did not find any records or evidence indicating that advanced care planning (ACP) had been put in place for any of the patients' notes we looked at, or patient and relatives we spoke with. However the LDCDA reminded staff to ask if there was an ACP in place, which could have been discussed with the patient's GP.
- We found that care planning in the last days and hours of life was individualised and holistic to reflect the patient's needs. The LDLCA looked at the whole picture and took into account the views of the patients and carers and their spiritual, emotional, psychological and social needs. The patient's preferred place of death was documented and this was shared with the other professionals involved in their care. However this was a new document and not all health professionals had started to use it for patients identified at end of life.
- The SPCT reported that, in recent years, there had been an increase in supporting more patients for EOLC than palliative care.
- We reviewed the trust's revised draft strategy for people living with dementia. The strategy focussed on how to improve the inpatient experience for those living with dementia through changing attitudes, the environment, raising awareness and having clear pathways for treatment and care.
- Patients' close family members were able to stay with their relative overnight and the facilities and arrangements were different for each ward at the hospital. There was no dedicated accommodation for patients' relatives.
- Some senior staff expressed a concern that there were not enough experienced generalist staff and as a result the junior staff were not supported adequately in making flexible decisions to support patients and those close to them at the end of life. For example allowing families unlimited visiting times or and moving the patient to a side room.
- Staff were aware that different cultures had a different approach to death and dying. Therefore the team approached difficult conversations about death and dying at a pace that the patient and family could understand.
- Patients and relatives could access a chapel and a multi-faith prayer room if they wished. The chapel was not open at night. There was a full time Church of England and a Roman Catholic chaplain available. Leaders from other faiths (Hindu, Jewish and Muslim) were available on a part-time and on-call basis.
- The mortuary staff had created an exemplary environment in the mortuary area. They ensured each of the deceased were cared for in an individualised way, taking into account their personal wishes and any requests made by those close to them.We found the multiple systems of cross checking, which had been developed by the mortuary technician, ensured safe practices in all areas of their work at all times.
- The hospital had a bereavement office. However, this was not an ideal space as it was the first office in the hospital's main reception area. Bereavement staff told us people often interrupted meetings and the space was too small to accommodate more than one or two people. Staff provided relatives with information, the death certificate and a booklet on what happens after death.
- The trust had access to translation services through language line or face-to-face interpreters. There were a number of staff who spoke other languages.

End of life care

Learning from complaints and concerns

- End of life services received very few formal complaints. We were given a clear explanation of how complaints were handled and the role of the service managers in responding to them. All staff told us they preferred to deal with issues or complaints immediately and offered a face-to-face meeting with the complainant. If they found the issue could not be dealt with in their way they supported people in making a formal complaint to the trust.

Are end of life care services well-led?

Good

We rated well led in end of life care as good.

The service had a clear statement of vision and values, driven by safety and quality. All staff we spoke with were committed to providing safe and good quality care.

The SPCT regularly engaged with staff on generalist and specialist wards by providing support, training and assessing the appropriateness of the care they were providing. Ward staff were aware of the specialist support available to them.

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

Staff reported an improved emphasis on EOLC at board level over the last year. However the perception was that it was still seen as the responsibility of the palliative and cancer services to drive it forward the vision for EOLC to be everyone's responsibility would not be reflected.

Vision and strategy for this service

- The trust had recently written the EOLC strategy which was currently in a draft format and out for consultation. The strategy identified that for the trust to deliver high quality, equitable and compassionate EOLC core principles needed to be followed across the whole of the acute and community services. These core principles of EOLC included the recognition of the possibility that a patients might die, communicating clearly and honestly with the patients and family, understanding the priorities of care of the patient and family, and delivering co-ordinated care enabling the patient to die in the place of their choosing if possible.
- The SPCT at Ealing Hospital were unclear about the strategy and vision for palliative and end of life care service since the merger of the hospitals within the LNWHT. They were unsure how the strategy, which was driven by SPCT at Northwick Park, would transfer to services at Ealing.
- EOLC group meeting minutes showed how the EOLC strategy and vision was fed to the trust's board via the clinical cabinet and any feedback was discussed and recorded at the following EOLC group meeting. This group had representation from various directorates such as elderly care, A&E and AHP across the trust and therefore it was possible for this information to be disseminated to staff at all levels through each directorate across the trust.

Governance, risk management and quality measurement

- A clinical governance meeting took place four times a year where incidents and risks were explored and any trends identified. There was a clinical lead and board representation for EOLC.
- There was a plan to sign up to the 'NHS Improving Quality Transform Improvement Programme' however they required a designated service improvement lead before they could do this. We noted that meeting minutes had identified people who could possibly take on this role. The transform programme streams of work included: advanced care planning, electronic patient record for OOHs care, rapid discharge home to die, five priorities for care for the last days of life and care after death.
- The trust took part in a number of national audits, such as the NCDAH, which they had just completed. There was a plan to audit the 'Last Days of Life Care Agreement' in the next few months to see how accurately the document was being used and how well it supported patient care; and after a recent review of 50 sets of notes the team have decided to reviewed the notes for the first ten deaths each month to feedback on the quality of recording and identify any gaps, trends or concerns.

End of life care

- EOLC group meeting committee met every two months and included range of staff from across the trust acute and community locations including consultants, SPCNs, the medical director, the divisional head of nursing, elderly care and the resuscitation officer. Recent minutes recommended identifying ward managers to attend the 'EOLC Group' meetings; the aim was to increase EOLC and the five priorities of care profile and encourage ward manager to take greater responsibility for monitoring care around their dying patients.
- The SPCTs held weekly MDT meetings and bi-monthly business and educations meetings. The team discussed new and deteriorating patients and those that had chronic illness or were of concern. They considered the patients from a holistic point of view taking into account their social and psychological needs and assured that
- The SPCTs engaged with their acute peers and other CNSs or specialist palliative care nurses through meetings / informal discussions. The consultants worked within the community and at the acute hospitals this allowed them to address issues or share learning with the teams and offered consistency in support for patients under their care.
- A clinical forum discussed and reflected on cases that were difficult or ethically challenging. After significant event analysis and death reviews allowed the team to discuss the outcomes for the patient and those close to them, identify any issues, learning and share good practice.

Leadership of service

- The CNSs at Ealing Hospital expressed there was some distance between the services at their hospital and those at Northwick Park. They told us they were partly listened to but they perceived they had little control over any changes or development to services.
- In the last year (since September 2014) the EOLC profile had increased and had a "larger voice" through the medical director, this had given the subject" more authority". The consultant leads told us although there was trust board representation they did not feel that EOLC yet received the level of support it required.
- The SPCT told us they were passionate about all staff in the hospital providing a safe and good quality of care for end of life patients and therefore it was everyone's responsibility and not just that of the SPCT to ensure this happened. Therefore they strongly encouraged other staff at all levels throughout the hospital to be involved in EOLC.
- Staff told us they were supported by senior managers, in particular the divisional head of nursing and lead nurse for cancer and palliative care. They found them to be helpful, knowledgeable and approachable.
- There were clear lines of accountability within the palliative care management team based at Northwick Park Hospital. The clinical leads were enthusiastic and proactive in helping drive forward the end of life agenda within the trust. The clinical leads sat on the EOLC steering group which sat across the whole of the trust.

Culture within the service

- Ealing Hospital had a community hospital atmosphere. Many staff had known one another for a number of years and many patients had used the hospital for a long time.
- Mergers can create uncertainty about the future of some services. However, this did not affect the level of commitment the CNSs had to providing good end of life care for patients. We observed that there was some relationship building with their colleagues at Northwick Park Hospital.
- Staff reported an open culture where they could raise and discuss any concerns with their team and manager. The specialist nurses told us they were supported by their manager and told us any issues were dealt with quickly.
- The SPCNs told us they perceived they were valued by other the teams at the hospital who valued the support they gave.
- Staff did not feel as valued by the trust wide team and reported that all the good work they had done such as training staff at induction had been dismissed as it 'was not the Northwick Park way'. The leads told us they had adopted some of Ealing Hospital's policies such at their 'Last Offices (Care after Death)' policy.

Public and staff engagement

- The SPCTs engaged with staff on the ward on a regular basis. The SPCT spoke positively about the engagement they had with the ward staff and thought this had shown some increase in nursing staffs' understanding of palliative and EOLC.

End of life care

- The service found it was difficult to obtain formal feedback from patients or bereaved relatives as survey cards were rarely responded to. They had sent 45 surveys to bereaved relatives of which three came back. The three comments they received were positive about the contact they had with the CNS and there was one comment about poor staffing levels on the wards. Staff spoke with patients on a one to one basis to obtain feedback about the service.
- There was patient representation on the EOLC strategy group to give the patients and their families "voice" in discussions about the future strategy for EOLC across the trust.

Innovation, improvement and sustainability

- All staff in the SPCT, including nursing, medical, allied health professional within end of life services demonstrated a strong focus on improving the quality of care and people's experiences through a range of local and national audits, pilots, surveys, feedback and teaching across the community setting.
- The joint working between the acute service and community hospice was helping to develop and promote education in EOLC and provided patients with seamless support.

Outpatients and diagnostic imaging

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

Information about the service

The outpatients inspection team consisted of a CQC inspector, a medical consultant, a nurse consultant, a radiographer and a nurse. During our inspection we visited the main outpatient area and visited the clinics for cardiology, orthopaedics, phlebotomy, general outpatients, fractures, radiology and medical records.

We spoke with 39 members of staff including receptionists, nursing staff, allied healthcare professionals such as radiographers, healthcare assistants, consultants, doctors, administrators and service managers for surgery and urology.

We spoke with 12 patients at Ealing Hospital. We inspected the patient environment, and observed waiting areas and clinics in operation.

Summary of findings

Overall outpatient and diagnostic services at Ealing Hospital were good because there were systems in place to identify record and review incidents and staff were aware of how incidents should be escalated and recorded.

Outpatient and diagnostic services were visibly clean and there were processes to ensure cleaning was maintained.

We saw good evidence of how the diagnostic services benchmark their services through national and local audit activity and national guidelines including NICE and Royal College of Radiologists.

We found staff were compassionate, caring and proud to work at Ealing Hospital.

We saw evidence the hospital had variable performance in the National Cancer Patient Experience Survey 2014 some which placed the trust in the bottom 20% of trusts.

Mandatory training was provided however staff told us face to face training was often difficult to access or attend due to clinical commitments.

Hard copy records were not always available in time for clinics; the trust was aware of this and had started phased plans to integrate hard copy records in preparation for a move to an electronic record management system across all sites.

Outpatients and diagnostic imaging

The service had a backlog of patients waiting more than 18 weeks for an appointment and had attempted to reduce waiting times for patients, but financial constraints meant additional clinics had been stopped. There was a good system in place which highlighted the patients who had waited longest and should be clinically prioritised for the first available appointments.

We found inconsistencies in classification of some incidents and there was a lack of a well-considered strategy with clear goals, key staff allocated and clear timeframes for achievement of goals for outpatient services at Ealing Hospital. There was no evidence of audit activity in outpatient services.

Are outpatient and diagnostic imaging services safe?

Good

Overall we found the safety of outpatient and diagnostic services was good.

We found staff were aware of how incidents were escalated; there was information available about the Duty of Candour for patients and staff. There were no never events identified within outpatients and diagnostic services at Ealing Hospital. We saw evidence of a robust serious incident investigation and learning objectives were set following the incident.

Areas visited were visibly clean, there were cleaning schedules available and equipment was identified as clean by use of green 'I'm clean' stickers. We found not all staff who were required to do so had completed infection control training.

Resuscitation equipment was regularly inspected and records of the checks were consistently made. We saw evidence that radiology equipment was maintained and monitored for safety.

Medicines were stored securely but the key holder for medicines cupboards was not always a clinically qualified staff member.

We found information the majority of staff (92%/64%) were up to date with mandatory training. The majority of staff in outpatients and radiology had been trained in safeguarding and some of the staff we spoke with were aware of safeguarding issues. There was a good process in place which ensured concerning test results were drawn to the attention of referring clinicians.

We saw risks associated with exposure to radiation were documented and local rules which included restricting access to high risk areas were available.

We found the trust had set a target for staff completing mandatory training of 75%, this was monitored and exceeded for some training for example health and safety compliance was 92.6% for outpatients and 80.4% for radiology staff.

Outpatients and diagnostic imaging

We saw that recruitment was challenging, but monitored by the trust and bank staff were regularly used to cover gaps in rotas.

However, we found evidence that incidents were monitored in different ways by different parts of the service.

The method for tracking medical records was not always reliable and compilation of clinic lists was in some cases cumbersome and included printing hard copies of test results which were available electronically.

Incidents

- We were not assured incidents were consistently monitored and managed.
- The trust provided a copy of the incident tracker for Ealing Hospital and which showed there five serious incidents being investigated between 27 February 2014 and 23 September 2015. These were difficult to reconcile with the Datix incidents and appeared to be different. Of these, two related to radiology and one each related to pharmacy, cancer services and one related to the outpatient fracture clinic.
- The trust had an incident and near miss reporting policy dated February 2015. This policy contained a list of the untoward events classed as never events. There were no reported never events relating to the outpatients or diagnostic departments at Ealing Hospital. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.
- We saw the root cause analysis investigation for a pressure ulcer sustained by a patient in fracture clinic in June 2014 was robustly investigated and recommendations included how to share learning within the team. We did not see evidence that this had been shared with the team.
- Serious incidents were categorised as severe or moderate harm. There were four serious incidents attributed to the outpatients and diagnostic services between 1 July 2014 and 31 July 2015. Records showed serious incidents were not wholly attributed to outpatients, but were referenced under the speciality and this made identifying serious incidents related specifically to outpatients difficult.
- Of the serious incidents identified, three related to delayed diagnosis in radiology and one related to pharmacy.
- The pharmacy incident stated regular epilepsy medicine was not dispensed. A patient's regular medication did not include epilepsy medication and the pharmacy had not queried this when they made up the prescription. The medication error was not spotted before the patient deteriorated at home.
- Eleven of the staff we spoke with were asked about and were aware of the trust incident reporting procedure using Datix and four of them explained the Duty of Candour.

Cleanliness, infection control and hygiene

- Disposable curtains were used in the main outpatients area; these were dated and we saw green 'I'm clean' stickers on equipment in the department.
- There was a cleaning schedule and cleaning instructions were available in the outpatient department. We did not see evidence of audit of cleaning.
- There were no occurrences of clostridium difficile attributed to outpatient services between April and July 2015.
- Endoscopes in the ear, nose and throat department were cleaned using Tristel wipes and there was a tracking and recording system in place.
- Information from the trust showed 91% of outpatient staff and 61.9% of radiology staff had completed infection control training.
- Alcohol hand gel dispensers were available at entrances to outpatient clinics.
- We observed phlebotomy staff wearing personal protective clothing for example aprons and disposable gloves.
- Radiology had completed a hand washing audit which showed doctors were 96%, nurses 100% and radiographers 98% compliant. No recommendations were made about these results.
- Clinical staff wore short sleeved uniforms in colours that denote their role. For example white for phlebotomists.

Environment and equipment

- Resuscitation equipment was available in cardiology, outpatients and orthopaedic clinics. We saw evidence they were regularly inspected by staff and records of these checks were consistently made.
- We saw evidence that personal protective wear including lead aprons were checked for defects.

Outpatients and diagnostic imaging

- We saw evidence that a maintenance schedule and contract was in place for radiological equipment at Ealing Hospital covering the period October 2013 to October 2016.
- However, a consultant in the ear, nose and throat clinic (ENT) expressed concern about the limitations of the number of available endoscopes; there were two endoscopes that were used to treat up to 28 patients.
- Radiology staff told us that one computerised tomography (CT) scanner was old, had been condemned but remained on site pending procurement of a replacement. Staff told us space was at a premium and if they had the condemned scanner removed before a new scanner was made available they might also have to relinquish the space. The radiology manager had provided the trust board with a business case for replacement scanner in May 2015 however minutes from the radiological protection committee in September 2015 showed no decision had been made to purchase a replacement.
- The service had an annual plan for audits in radiology, this included audits relating to IR(ME)R. Staff told us their next IR(ME)R audit was due to be done in February 2016.
- The IR(ME)R audit for Ealing Hospital on compliance with IR(ME)R report from March 2015 showed 'significant assurance' that the guidance relating to ionising radiation regulations were being followed.

Medicines

- We found medication was appropriately and securely stored in the cardiology clinic, outpatient clinic and phlebotomy, and fridges containing medicines which required chilling were consistently monitored and recorded without gaps.
- However, staff in the ear, nose and throat (ENT) clinic told us there was no registered nurse in the clinic and the healthcare assistant held the keys for the drug cupboard. The healthcare assistant was also responsible for allocating the prescription pads to the treating consultants. We were told a record of the numbers of prescriptions handed out was made, but we didn't see the record and were told this was not audited. We were concerned that an unqualified member of staff was given this responsibility.

Records

- The medical records manager told us she tried to ensure records were available in time for clinics.
- A temporary medical record was created when the main patient notes file could not be found. Temporary patient records were also held within the medical records department and these were where stored in the same shelves and amalgamated when the files were next picked for a clinic.
- Medical records staff compiled a list of records seven, three and one day before clinics and included printed off test results which were available electronically. Our inspectors believed the practice of printing off test results electronically available was cumbersome and unnecessary.
- The method for tracking medical records was not always reliable. Notes were stored in the medical records department and were collected by medical records staff in preparation for outpatient clinics. Notes had an electronic barcode tracking system for traceability however, they were not always found because staff did not always use the tracking system to sign records in or out of a department. The medical records manager told us this was often because a clinic or department had borrowed the records to complete for example a letter to be sent to the patient's General Practitioner (GP) but had not used the electronic system to sign them out.
- The medical records managers told us missing records were a daily occurrence and they used the Datix system to report missing or lost health records. We asked these managers to show us an example of reporting however neither could remember the correct password and they were not able to access the Datix system.
- The patient records programme manager told us the board had reviewed a three phase plan to unify patient records processes starting by unifying the hard copy notes and ending with implementation of an electronic patient records system. He showed us a copy of the phased plan which had been presented to the board in September 2015. We did not see evidence of the decision taken by the board about the phased plan.

Safeguarding

- Information provided by the hospital showed 93.2% of radiology staff required to undertake safeguarding adults training Level 1 had completed this training and 76.7% of staff required to undertake safeguarding adults training level 2 had completed this.

- Information provided by the hospital showed 82% of outpatient staff required to undertake safeguarding children Level 1 had completed this and 75.6% of staff required to undertake safeguarding children training Level 2 had completed this training.
- One band 5 nurse in children's outpatients told us she had been trained in safeguarding Level 3. We did not see evidence that paediatric staff had undertaken safeguarding training Level 3.
- Three of the staff we spoke with told us they were up to date with safeguarding training and were aware able to describe previous safeguarding concerns that had been escalated.
- We saw evidence on the outpatient noticeboard that chaperones were available.
- We saw evidence the radiologists had a procedure which ensured urgent reports were escalated to medical secretaries who in turn draw urgent information to the attention of the referring specialist.
- However, staff in the ear, nose and throat (ENT) clinic told us children were not seen on the same day as adults. However, on the day we inspected there were five children waiting for appointments. We drew this to the attention of the matron who told us she would take this up with her manager.
- Staff in the ENT clinic told us of another incident when children were waiting to be seen and a mental health patient was brought to the department restrained in handcuffs. We asked the matron about this, she told us at the time there was no method for identifying patients with particular needs prior to their attendance and she was attempting to set a system up.

Mandatory training

- The trust target for integrated clinical services teams' completion of mandatory training was above 75%. Mandatory training for this trust included equality diversity and human rights, fire safety, health & safety, major incident awareness, infection control, manual handling level 1 and Level 2, Mental Capacity Act Level 1, prevention of terrorism (known locally as prevent) and information governance.
- Outpatients staff had completed training as follows: equality diversity and human rights 83%, fire safety 73.4%, health & safety 92.6%, major incident awareness 57.8%, infection control clinical 57.8% (non-clinical 91%), manual handling Level 1 85.7% and Level 2 86.%, Mental Capacity Act Level 1 78.3% and prevention of terrorism known locally as 'prevent' 51.9%and information governance 80.4%.
- Radiology outpatients staff had completed training as follows: equality diversity and human rights 67%, fire safety 74.6%, health & safety 80.4%, major incident awareness 35%, infection control 61.9%, manual handling level 1 56.5%, Mental Capacity Act Level 1 60%, prevention of terrorism known locally as prevent 38% and information governance 54.4%.
- Three staff told us they were up to date with mandatory training.
- We saw evidence in minutes of the clinical governance meetings that the trust monitored the update of mandatory training.
- However, a further three told us there were gaps owing to clinical commitments making attending face to face training more difficult than electronic self-learning.

Assessing and responding to patient risk

- The trust had an appropriate process whereby senior clinicians reviewed the data about patients waiting for overdue appointments and these were graded according to a low, moderate or high risk of harm and the trust provided sub-specialty clinics for patients where a delayed follow-up would lead to clinical risk. For example Glaucoma.
- The radiation protection supervisor told us that a radiation protection committee was established when the trust merged, key documents including the local rules for radiation protection were updated during the summer of 2015 and (radiation) dose reference levels were being revised.
- We saw evidence of the updated local rules for radiology and they cross referenced the Ionising Radiation (Medical Exposures) Regulations (2000), (IRMER). The local rules included the steps required to restrict access to the areas where radiological testing was carried out.
- The outpatients risk register identified five issues of concern including lack of capacity, temperature in the women's clinic environment, lack of availability of complete medical records, overbooking clinics and absence of a dedicated plaster sink in the plaster room.
- Each risk register entry had a time bound action point to mitigate the risks. For example the trust used fans and had obtained quotes for fitting air conditioning in the women's clinic area and

- Lack of availability of medical records was cross-referenced in the main trust risk register. We saw that an outline business case had been made to the board in September 2015 for purchase of an electronic document management system (EDMS). We did not see minutes for the September board meeting.

Nursing staffing

- Outpatients are part of the integrated clinical services division. Information provided by the trust showed there were consistent shortfalls in the nursing establishment of up to 20%.
- The outpatients general manager told us that they did not use agency nursing staff however they did use bank staff and we saw evidence demonstrating bank staff cover for some gaps in the rotas.
- We saw nurse staffing rotas for May to September 2015. These showed the names and grade of the nurses, but not the clinics assigned to them. There were regular gaps owing to sickness absence. For example week commencing 5 September there were two healthcare assistants and one band 5 nurse sick for the week. We saw that there were three bank healthcare assistants who regularly covered the outpatients department, but could not identify if this was to cover gaps owing to sickness absence or vacancies.
- Radiology staff told us they work across all sites. We asked for copies of rotas, we saw the rotas for Northwick Park and Central Middlesex Hospitals and that demonstrated staff worked between these two hospitals. We did not receive rotas for Ealing and could not corroborate that staff from radiology in Ealing work at either of the other hospitals run by the trust.
- Staff perceived a level of inequality of the number of clinical nurse specialists compared to Northwick Park Hospital. We did not see evidence of the numbers of clinical nurse specialists at either Ealing or Northwick Park Hospital.

Medical staffing

- The assistant director of nursing told us there were no medical personnel directly employed by outpatients. Medical staffing was provided by the specialities; for example in cardiology, there were six consultants who had split contracts and also worked for other west London hospitals.
- We saw evidence in the radiology consultants meeting minutes for 9 July 2015 there were two radiologist vacancies at Ealing Hospital and three locum posts. The minutes recorded applicants for the radiologist posts had been shortlisted for interview in September 2015.

Major incident awareness and training

- We saw evidence all staff were required to complete anti-terrorism and major incident awareness training.
- The trust had a business continuity plan dated January 2015. None of the staff we spoke with mentioned this plan. However, the plan included a flow chart to cascade information between other relevant parties should a disruptive incident occur such as loss of electricity supply. The flow chart included numbers for other agencies such as ambulance and fire and rescue services.

Are outpatient and diagnostic imaging services effective?

We found of the effectiveness of diagnostic services was good however we found less evidence that outpatient services were good.

We saw evidence the radiology department had appropriate systems, key documents for managing and responding to risk and participated in audit of some national guidelines. We did not see evidence that outpatients at Ealing Hospital participates in audit activity.

We found the trust provided training for people with particular vulnerabilities for example dementia through Mental Capacity Act training and staff we spoke with described how they supported people with dementia.

Results from the National Cancer Patient Experience Survey 2014 showed Ealing scored well in explanations to patients about their cancers and less well in providing clear information for patients to take from a consultation.

Evidence-based care and treatment

- The radiology department carried out a variety of national and local audits of guidelines including the Royal College of Radiologists referral guidelines and British Thoracic Society guidelines of suspected pulmonary embolism and NICE guideline no 144 (Venous thromboembolic diseases).

Outpatients and diagnostic imaging

- Radiographers followed guidelines based on NICE guidance for screening and diagnosis of bowel cancer which also followed Royal College of Radiologists Guidelines.
- We saw a copy of the local rules for the imaging department. These had been revised and updated in August 2015 and included how to restrict access to high risk areas and how to ensure patients and staff were protected from unintended doses of radiation. The local rules included key safety information about exposure, for example to ensure that x-rays were clinically justified and staff wore personal protective monitors and equipment such as lead aprons.
- The nurse in charge of outpatients told us an audit of patient waiting times at clinic was ongoing. This was not on the priority audit list seen for surgery and critical care or the Integrated Clinical Services audit report August 2015.

Pain relief

- None of the 12 patients we spoke to raised pain relief as a complaint and none of the complaints related to outpatients services were about pain management.
- The trust scored well in the National Cancer Patient Experience Survey 2014 for questions related to pain management for outpatient care: 'Staff definitely did everything they could to help control pain' 80% and 'Staff definitely did everything to control side effects of chemotherapy' 92%.
- We were told there was no pain management clinic at Ealing Hospital however a trust wide pain management clinic was held at Central Middlesex Hospital.

Patient outcomes

- The results of the National Cancer Patient Experience Survey 2014 showed this hospital scored well for the following questions: 'Staff gave complete explanation of purpose of test(s)' 8%; 'Staff explained completely what would be done during test' 90%; 'Patient told they could bring a friend when first told they had cancer' 67%;'Patient completely understood the explanation of what was wrong' 75%.

Scores were less positive for 'Given easy to understand written information about test' 73% and 'Given complete explanation of test results in understandable way' 71%.

- We saw evidence Ealing Hospital participated in audit of Royal College of Radiologists Referral Guidelines in summer 2013 entitled 'Making the best use of clinical radiology'. This audit cross -referenced NICE guideline 144 for venous thromboembolic diseases. Results showed the hospital changed the form used for referrals to ensure key risk information was included to indicate suspicion of a pulmonary embolism. This was re-audited and identified improved information was provided on the revised referral forms.
- We saw evidence of an audit of radiology requests was carried out in the summer 2014 against the same Royal College guidelines. The audit compared paper versus electronic referral information and concluded that electronic was more complete than paper.
- The audit included review of cross-checking the appropriateness of the requested scan .There was a target for cross-checking of95% which was met and a 90% target for ensuring the scan was justified was exceeded (98%). Recommendations were made to incorporate more time for cross-checking in job plans and to promote electronic referrals over paper.
- However, we did not see evidence of participation in the Imaging Services Accreditation Scheme (ISAS).
- We did not see evidence of participation in the Improving Quality in Physiological Services (IQIPS) accreditation scheme.
- We did not see evidence of audit activity within outpatients departments.

Competent staff

- Information provided showed across the trust 92% of outpatient staff and 64% of radiography staff had an up to date appraisal.
- We saw that completion of mandatory training was acknowledged on the trust risk register. The steps for mitigating the risk included the introduction of an electronic learning system and weekly and monthly monitoring of compliance at divisional level.
- Three staff in medical records told us about training sessions that took place on alternate Fridays for one hour to ensure medical records staff were updated with key information relevant to their department.
- The radiology manager told us they work with the University of Hertfordshire who send students to the trust and many of the graduates stay.

- In the radiation protection advisor's report February 2015, there was evidence staff had been IRMER trained, there were annual updates and further on-line radiation protection training was available through the radiation protection advisor and supervisor.
- We saw evidence on the corporate risk register that weekly monitoring the uptake of mandatory training commenced in September 2015, we did not see evidence of how the trust would ensure all staff had an up to date appraisal.
- We were told the lead radiographer had advanced training in CT reporting, but was often not able to carry out this work owing to staff shortages. The radiology manager told us there was a national recruitment problem and they supported training of band 5 radiologists to enable promotion within the trust but this then leaves a gap in band 5 staff. This was not identified on the trust risk register.
- The radiology manager told us freeing up staff to complete training was a challenge owing to vacancies and clinical commitments.
- Revalidation of doctors' information was provided for the whole trust. This information showed there were 433 doctors requiring revalidation across the trust. It was not possible to tell from this information which of the 69 doctors' revalidation had been deferred pending more information or the three fitness to practice panels related to medical staff practising within the outpatient departments.

Multidisciplinary working

- We saw evidence in June 2015 clinical governance minutes pharmacy staff shared with phlebotomy staff who passed on risk information to pathology colleagues about the risks associated with multiple and different identification information for individual patients.
- We were told that the cardiology service offered a consultant led one-stop clinic each weekday which saw three patients.
- We saw evidence that the radiology department audited the appropriateness of general practitioner (GP) referrals to prevent unnecessary exposure to radiation doses between March 2014 and March 2015. The results showed that 100% of referrals were cross-checked for appropriateness by a radiologist and 97% of the first requested test was carried out as the most appropriate first investigation.
- We also saw that the radiology department had audited 'Concordance rates between radiographers and radiologists in the decision to give contrast' between June 2014 and June 2015 and that this results showed agreement of the appropriateness of this in all but one referral.
- A cardiac research technician told us about a research project investigating the risk factors for heart disease and diabetes in the local community. Patients were referred by their GP. The London Life Sciences Prospective Population Study known as the LOLIPOP study had been running since 2002 and comprises detailed health assessments for people living in West London. Up to 30 patients a day were screened by Ealing hospital. The research was co-funded by the National Institute for Health Research (NIHR) and a pharmaceutical company.
- The physiologist working in cardiology told us patients' GP's could make referrals for same day service to a walk-in echocardiogram service (ECG) service.

Seven-day services

- The radiology manager told us diagnostic services staff had begun to function as an integrated team and worked across the three trust hospital sites. They had changed their working patterns to cover on-call working for evenings and weekends.
- Magnetic resonance imaging (MRI) and CT scanning was provided 8am to 8pm seven days a week. The rotas included named staff to cover on-call work for CT scanning but not MRI.
- However, we did not identify any out of hours outpatient clinics run from Ealing hospital.

Access to information

- The IT department staff told us about problems which had been identified earlier in the year when a new radiology information system (RIS) was implemented as part of the implementation of the business case above and which had caused a backlog because staff were unfamiliar with the new programme and took longer to complete tasks.
- A senior radiology manager told us the backlog often prevented them from reporting results in real time due and their goal was to eliminate the backlog and report

results in real time. The radiology manager told us there remained a backlog of approximately 2400 test results. We saw this risk represented on the corporate risk register.
- We saw evidence on the trust risk register of the two serious radiology incidents but not the backlog of tests which required reporting.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Information provided showed the trust provided Mental Capacity Act Level 1 training to staff across the trust and 78.2% of outpatient staff and 62% radiography staff were up to date with this training.
- Six members of staff told us how they supported people who lacked capacity. For example supporting those with dementia or learning difficulties by seeking the advice of the learning difficulty champion within the department.
- One member of staff also told us that people with dementia were fast tracked to see the consultants without having to wait with other patients.
- The trust had a policy for consent to examination or treatment which was last reviewed in September 2012.
- There was evidence the trust had audited consent, but this was limited to in-patient wards. We did not see evidence of a consent audit in outpatients.

Are outpatient and diagnostic imaging services caring?

Good

Overall we rated caring by staff in outpatient and diagnostic services as good.

We observed staff interact with patients in a positive, friendly and compassionate manner.

Patients' privacy and dignity was maintained during checks which included weight and blood pressure were done in consultation rooms with doors closed.

However, we also saw evidence from the National Cancer Patient Experience Survey 2014 which placed the hospital in the bottom 20% of trusts for the question 'Patient reported they were told sensitively that they had cancer'.

Compassionate care

- Staff in outpatients and diagnostic services were multi-cultural and demonstrated passion for their roles. For example a band five nurse in outpatients told us she had recently returned to work for the trust in outpatients although she had trained in paediatrics, but said working in outpatients was very worthwhile.
- Mostly we saw staff interacting with patients in a caring, compassionate way. For example we saw staff in outpatients informing patients of waiting times for clinics.
- Trust results for the friends and family test (FFT) for July 2015 showed 97% of 387 respondents were highly likely or likely to recommend outpatients at the hospital.
- A staff nurse in the ear, nose and throat department told us she ensured patients who had been in the department for up to four hours were offered food and drink.
- We saw six completed FFT forms in the cardiac catheter laboratory had been completed and stated they would recommend the hospital.
- The noticeboard in outpatients contained information about staffing levels, a picture and contact details for the matron and how to contact the patient and advice and liaison (PALs) team to provide feedback or raise concerns.
- We saw that observations such as weight and blood pressure monitoring were done in a room with the door closed to assure patients privacy and dignity.
- The trust scored well in the National Cancer Patient Experience Survey 2014 for questions related to outpatient care for 'Doctor had the right notes and other documentation with them' 96%.
- However, we also saw evidence from the National Cancer Patient Experience Survey 2014 which placed the hospital in the bottom 20% of trusts for the question 'Patient reported they were told sensitively that they had cancer'.

Understanding and involvement of patients and those close to them

- Patients with whom we spoke with did not raise concerns about involvement in their care.
- Patients' privacy and dignity during checks which included weight and blood pressure were done in consultation rooms with doors closed.

Outpatients and diagnostic imaging

- The trust scored less well in the National Cancer Patient Experience Survey 2014 for questions related to outpatient care for 'Family definitely given all information needed to help care at home' 56%. This placed the trust in the bottom 20% of trusts.
- We did not speak to any relatives of patients on the day we inspected.
- However, three patients we spoke with told us about the long waits in clinics.

Emotional support

- One patient told us they attended outpatients regularly, rarely waited more than half an hour and were sometimes late for their appointment, but were still seen.
- We saw evidence of involvement of other teams on the waiting room notice board. For example how to access an interpreter or how to contact the Patient Advice and Liaison department (PALs).
- However, the trust scored less well in the National Cancer Patient Experience Survey 2014 for questions related to outpatient care for 'Hospital staff definitely gave patient enough emotional support' 66%. This placed the trust in the bottom 20% of trusts.

Are outpatient and diagnostic imaging services responsive?

Good

Overall we judged that responsiveness of outpatient and diagnostic services was good.

Patients referred to the outpatients service were given the first available appointment at Ealing Hospital but could choose to attend one of the other two hospitals run by the trust. We saw evidence that patients would recommend the trust to friends and family. We saw evidence that trust provided patient information within the outpatient clinic.

The trust had a process for identifying the patients near to having waited 18 weeks and escalated this information to the speciality clinics to which patients' had been referred. We were told about a one-stop clinic run by cardiology.

Staff were able to describe how they supported patients with vulnerabilities such as patients living with dementia. Information was available in the outpatients department to help patients provide feedback or make a complaint.

Following implementation of a new IT system that caused a backlog radiology staff changed their normal working pattern to be able to open radiology between 8am and 8pm as part of the measures to reduce the resulting backlog caused by implementation of the new IT system.

However, we saw evidence that half of the complaints patients had made about outpatients and diagnostic services at Ealing Hospital were the result of poor communication between the hospital and patients or other departments within the hospital.

The trust had a backlog across most outpatient specialities of 386 patients who had waited more than 18 weeks, for example the longest waits were for cardiology services. The trust had high did not attend rates (DNA) and had piloted sending patients text reminders of their appointments, but this had been terminated without being evaluated.

Additional clinics at weekends had been provided to address some of the backlog, but we were told these would cease in November due to financial constraints.

Service planning and delivery to meet the needs of local people

- Patients referred to outpatients at Ealing Hospital could choose to attend outpatients there or at one of the two other hospitals run by this trust, Northwick Park Hospital or Central Middlesex Hospital. Patients with urgent needs, for example two-week wait cancer patients were given the first available appointment regardless of location.
- Staff told us there had been a surge in demand for outpatient services across the trust. The trust provided information that showed there had been 569,126 outpatient referrals in 2013-14 and 790,724 in 2014/15. This equated to a 39% increase.
- The trust had high did not attend (DNA) rates of between 5.5% for oncology and 20% for respiratory medicine. Cardiology staff told us patients who do not attend but were suspected of having cancer were offered a second appointment. This was confirmed in the patient access guidelines document dated 13 March 2014.

- Patients GP's were sent a letter advising of patients who did not attend for an appointment.
- Cardiology staff told us that non-urgent patients who do not attend were not routinely offered a second appointment.
- Patients attending for catheterisation appointments for example for angioplasty or angiography in the catheterisation laboratory attended, were assessed by nursing staff the week before procedures and checked for bacterial infections such as MRSA.
- The trust trialled using text messages to remind patients of their appointments to reduce the DNA rate. The chief executive and the outpatients general manager told us about the pilot. . The medical records manager told us it didn't work and the outpatients general manager told us it was stopped because of financial constraints. We asked to see the evaluation evidence for the text pilot however no evaluation of the pilot had been completed.
- We saw notice board information in the main outpatients area identifying the staff working there and with contact details for raising concerns if required.
- New seating had been purchased for the main outpatients department at Ealing Hospital.
- Some areas within the outpatients department were more suitable than others. For example we found the cardiology clinic had a sufficient waiting area, which was quiet on the day of our inspection and other rooms used for consultation were well equipped and clean.
- However, the fracture clinic was busy, cramped and on the day we visited patients were queueing in corridors whilst waiting for treatment.

Access and flow

- The trust had a backlog across the board of patients being referred for outpatient treatment. Hospital data showed 386 patients across all specialities were waiting more than 18 weeks for an appointment.
- The percentage of patients waiting over 18 weeks for treatment (June 2015) ranged from the lowest in colorectal surgery (11.9%); gastroenterology (17.2%); oral surgery (23.9%); general surgery (38.9%) and cardiology (46%).
- The service had a patient access guideline which referred to the national two week maximum waiting target for appointments for patients who required treatment of malignant disease. We saw that the divisions monitored the achievement of two-week referrals on a monthly basis and in July 2015 the divisions were achieving the following: integrated clinical services 98.9%; Women and children 96.5%; Medicine 93.8% and surgery 91.4% of patients' were given an appointment within two weeks.
- Service managers for surgery and urology told us extra clinics had been offered to address the backlog, but these would cease in November 2015 due to financial pressures. The trust monitored the backlogs on a daily basis and we were told held a weekly meeting across all sites to discuss progress. However, the weekly meeting had been cancelled during the week we inspected.
- The cardiology service delivery manager told us patients waiting for cardiology treatment required many diagnostic tests and this and patient cancellations sometimes delayed treatment.
- The service managers' told us consultants were looking to discharge patients for whom test results were normal and no follow up appointment was required since extra clinics were stopped. They told us there were weekly meetings to discuss progress reducing the backlog.
- The trust had consistently failed to meet the 95% target of patients referred to treatment within 18 weeks within the divisions of surgery and medicine. Information on the trust divisional performance scorecard showed that year to date (July 2015) the trust had achieved 92.04% for surgery and 93.88% for medicine.
- Diagnostic services performed better at 99.17%. However, the radiology service manager told us there remained a backlog of approximately 2400 test reports across the trust.
- The introduction of a new electronic radiology information system (RIS) for diagnostic testing including radiology in June 2015 resulted in a backlog of patients waiting for tests and an increased need for manual validation of electronic data. This was reflected on the corporate risk register.
- Radiology staff changed their normal working pattern to be able to open radiology between 08:00 and 20:00 as part of the measures to reduce the resulting backlog caused by implementation of a new IT system. The disruption to the service was reflected on the risk register and 384 test reports were outsourced to other providers.
- Two patients we spoke to told us they had waited 50 minutes and half an hour respectively since arrival.

Meeting people's individual needs

Outpatients and diagnostic imaging

- The general manager of outpatients and two outpatient staff told us they had telephone access via 'pink' telephones for people requiring translation services.
- Five members of outpatients staff told us patients living with dementia or patients with a learning disability were seen more quickly to avoid them having to wait and to minimise anxiety, but they were not aware of any attempts to make information known about these patients prior to their appointments We identified information on the trust website about a commitment to make reasonable adjustments for people with special needs. This included health passports for people with learning difficulties. However, none of the staff we spoke with mentioned these.
- We observed nurses updating patients about waiting times.
- Waiting times were displayed on the notice board in the main outpatients department along with other patient information, for example patient advice and liaison (PALs) information on how to complain and what to do if the patient required an interpreter for their consultation.
- We saw evidence that patients would recommend the trust to friends and family. We saw evidence that trust provided patient information within the outpatient clinic to assist patients. For example how to contact the patient advice and liaison service (PALs).
- We were told that there was a 'one-stop' cardiology clinic which saw up to three patients daily.
- One phlebotomist told us the cardiac clinic provided an anti-coagulation clinic and this reduced waiting time for phlebotomy patients.
- Some areas of outpatients were cramped and we observed a partially sighted patient in a wheelchair waiting in the corridor for the orthopaedic clinic. We asked this patient if that was satisfactory, he told us he was blind and didn't know he was in the corridor. Staff told us there was not room in the waiting room for the wheel chair.
- There was a rapid access for chest pain clinic that aimed to see clinics had been withdrawn owing to financial constraints. A physiologist told us meeting the two week target for the rapid access chest pain clinic would be more difficult in future. Cardiology services were not managed by the outpatient department and not reflected on the outpatients departmental plan.
- The phlebotomy manager told us that the space was not always sufficient to meet the needs of patients. We observed this space was cramped. We observed a visually impaired patient within in a wheelchair in the corridor of the orthopaedic clinic. We asked if a risk assessment had been done for this area and were told this was yet to be completed.
- Results of the national cancer patient survey 2014 showed the trust performs less well than the national average for 'clear written information about what should / should not do post discharge'.

Learning from complaints and concerns

- The trust used the Datix system to record complaints alongside incidents and we saw evidence there were further incidents related to outpatient and diagnostic services between 1 July 2014 and 31 July 2015.
- The trust had a complaints and concerns policy. We saw a copy dated October 2014 and this policy had been updated to take account of the Francis enquiry recommendations. The complaints procedure flow chart provided by the trust showed complaints should be logged on the Datix incident reporting system.
- There were 40 complaints about Ealing outpatient services between November 2014 and July 2015. The information was in summary rather than detailed format. Twenty related to poor communications for example: 'a patient attended a dermatology appointment and was left distressed by the treatment received as well as lack of communication regarding biopsy results'. Seventeen related to delayed or cancelled treatment, for example a patient experienced delay obtaining an appointment for removal of kidney stones; two related to medication changes and one related to an accidental fall in the ear, nose and throat clinic.
- Thirty-one complaints had been closed mostly within one month. Nine remained open, two had unexplained initials in the outcome field but all of them with remained open with no outcome detailed.
- A senior cardiology nurse told us that patients were more likely to complain about administrative errors than clinical care.
- We did not identify any staff who were aware of the new complaints procedure.

Are outpatient and diagnostic imaging services well-led?

Outpatients and diagnostic imaging

Good

Regular meetings took place to review mandatory training compliance, risk register reviews, audit of NICE guidelines, incident reports and safety alert bulletins.

The service scored well in some of the NHS staff survey 2014 indicators, for example in the 'Percentage of staff feeling satisfied with the quality of work and patient care they are able to deliver'.

Not all the specialities which provided an outpatient service are managed by the integrated clinical services division. The clinics which are not part of the outpatients department for example neurology, cardiology, dermatology, respiratory and haematology report to the divisional director for medicine. Vascular, breast care and urology departments report to the divisional director for surgery.

Vision and strategy for this service

- The service had a draft clinical strategy dated September 2015. This stated that quality improvements would be required to create a one stop Patient Access Centre for all patients. The plan included for example merging booking centre teams across all three acute hospitals, reducing did not attend (DNAs) by texting service users and developing an emailing system to reduce paper and postage costs. The divisional general manager, the divisional lead nurse and the general manager were named as the responsible leads for the plan.
- The trust had an information management and technology (M&T) strategy dated June 2015 led by the director of information technology (IT). The strategy confirmed the trust board had agreed in principle in March 2015 to implement a single digital record keeping system.
- The service had a divisional business plan 2015-16 led by the divisional clinical director.

Governance, risk management and quality measurement

- We saw agendas for a London North West Healthcare NHS Trust Legacy Ealing Clinical Support Services & CLIPS Clinical Governance Group for meetings that took place on 12 February, 18 June and 13 August 2015, which showed mandatory training compliance, risk register reviews, audit of NICE guidelines, incident reports and safety alert bulletins were discussed. The agendas included embedded documents, for example the divisional risk register, clinical audit report, training information and for August a risk assessment template for X-Ray & CT.
- The evidence we saw showed that a clinical governance meeting system was in place at which key risk information was discussed and included risk assessment, risk register reviews and other key safety information.

Leadership of service

- Staff from orthopaedic, general outpatients, radiology, ENT, phlebotomy and medical records told us managers were approachable and supportive and one healthcare assistant in phlebotomy described the outpatient sister as "brilliant" stating further that she had made positive changes and keeps staff well informed.
- Staff in in outpatients services told us the appointment of the matron had improved the profile of outpatients for example through accessing funding for new seating in the waiting areas.
- The merger last year provided an opportunity to assess the skill mix and structures for managing outpatient services including medical records and booking services. The trust had recently identified more work was required to streamline processes and had begun to identify key roles and responsibilities. We found the lead roles and accountability of the present leadership structure were currently split between four divisions.

Culture within the service

- Most of the staff we spoke with were enthusiastic about the trust and predecessor organisations.
- Some staff we spoke with perceived inequality between Ealing and Northwick Park Hospitals, for example about the numbers of clinical nurse specialists, work allocation and grading of medical records staff. For example we were told by radiography staff they had capacity to provide a service to some of Northwick Park Hospital patients, but were not given this opportunity.

Public engagement

- The trust used social media to communicate from the trust website. None of the staff we spoke with made reference to this form of communication with patients.

Outpatients and diagnostic imaging

- We held a listening event in October 2015 to gain the views of patients who used this hospital. One patient told us the cardiology department had been excellent. However, some feedback focussed on poor transport links and long waits for treatment upon arrival for appointments.
- We saw evidence in the NHS Choices web site patient feedback about outpatient and diagnostic services related to a good service in cardiology and a good experience of ultrasound but other feedback was mostly about long waiting times and one patient was unhappy about poor access for physically disabled people.

Staff engagement

- Radiology staff told us relationships with Northwick Park colleagues had been positive since the merger and anecdotally they had the lowest sickness absence rates in the trust owing to staff satisfaction in radiology. We did not look at staff sickness absence rates.

Innovation, improvement and sustainability

- Booking staff and service managers told us about attempts underway to reduce waiting times for patients including consultant review of diagnostic tests in urology and surgery and discharging patients with normal range test results who did not need to be seen for a follow up appointment. They used a patient tracking list which was checked daily and reminders were sent by the trust 18-week referral to treatment lead for patients who had waited almost 18 weeks without having an appointment.
- We were told about planned improvements which included moving to an electronic document management system.
- We were told by managers attempts to remind patients by text about their appointments and extra clinics to reduce backlogs had been discontinued owing to financial constraints.

Outstanding practice and areas for improvement

Outstanding practice

- We saw several areas of good practice or progress including:
- caring attitudes, dedication and good multi-disciplinary teamwork of clinical staff.
- good partnership working between urgent and emergency care staff and London Ambulance staff.
- good induction training for junior doctors.
- research projects into falls bundles, stroke trials and good cross site working in research.
- Staff told us there were good opportunities for training and career development.
- We found the specialist palliative care team (SPCT) to be passionate about ensuring patients and people close to them received safe, effective and good quality care in a timely manner.
- The play specialists in services for children demonstrated how they could make a difference to the service and its environment in meeting the needs of the children and young people. This included an outstanding diversional therapy approach for children and young people, which was led by the play specialist and school tutor.
- evidence of good antibiotic stewardship, particularly at Ealing pharmacy, with regular reviews of need; and the roll out of drug cabinets across certain parts of the trust with secure finger print access.
- patient satisfaction data collected by iPAD in one pharmacy location

Areas for improvement

Action the hospital MUST take to improve

- Instigate and continue an improvement plan in the emergency department to achieve mandatory targets including the 4 hour treatment target.
- Set an action plan to address poor performance against College of Emergency Medicine audit measures on pain relief, renal colic, fractured neck of femur and consultant sign off.
- Improve mandatory training levels and support for all staff to reach trust targets of 95%.
- Ensure COSHH assessments and arrangements are up to date and maintained.
- Ensure staff receive training and have their knowledge assessed in Mental Capacity and Deprivation of Liberty safeguards.
- Review infection prevention and control (IPC) practice and ensure correct IPC dress protocols are observed for all staff.
- Ensure patients' nutrition and hydration is monitored with fully completed records on medical wards.
- Improve record keeping with respect to fluid balance charts.
- Review IPC and improve cleanliness of equipment and fixtures on Ealing medical wards.
- Improve hand hygiene to show audits resulting in above 90% compliance and leading to 100%.
- Develop care plans which enable individualised information to be reflected and acted upon by staff.
- Improve referral to treatment times in surgery.
- Improve theatre utilisation and efficiencies related to start and finish times.
- Implement WHO patient safety checklists in all surgery settings
- Formally define care pathways in surgery.
- Improve provision of equipment for surgery.
- Ensure improvement in data completeness for patients having major bowel cancer surgery in line with the England average of 87% and up from the hospital performance of 30%.
- Review the surgical environment with respect to the needs of individuals living with dementia.
- Improve ventilation in the endoscopy department.
- Implement a hospital wide training programme to ensure ward staff understanding of end of life care and the Last Days of Life Care Agreement (LDLCA).
- Improve signage for patients in outpatient clinics.
- Review all arrangements and processes for the care and treatment of children at Ealing ED.

Outstanding practice and areas for improvement

- Take steps to examine and improve staff morale on Ealing medical wards.
- Review drug round timings to minimise medicines errors
- Review therapy visits on wards to prevent and minimise patients missing therapy.
- Review and improve facilities for patients living with dementia and remove inconsistencies of care.
- Address items on the OPD risk register including lack of capacity, lack of complete medical records, overbooking of clinics, and the absence of a plaster sink in the plaster room.
- Review medicines temperature control issues across all locations where medicines are stored.

This section is primarily information for the provider

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.