The Hillingdon Hospitals NHS Foundation Trust

Hillingdon Hospital

Quality Report

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Date of inspection visit: 1,2,3, 15 and 16 October 2014
Date of publication: 11/02/2015

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	**Requires improvement**
Surgery	**Requires improvement**
Critical care	**Requires improvement**
Maternity and gynaecology	**Requires improvement**
Services for children and young people	**Requires improvement**
End of life care	**Requires improvement**
Outpatients	**Requires improvement**

Summary of findings

Letter from the Chief Inspector of Hospitals

We carried out this inspection as part of our comprehensive inspection programme of all NHS acute providers.

Overall, this hospital was rated as requires improvement and we found that each of the eight core services we inspected at Hillingdon Hospital require improvement.

Our key findings were as follows:

- So far this year (2014/15), 87% of attendances in the trust's accident and emergency department had been admitted, transferred or discharged within four hours, against a national target of 95% of attendances.
- The trust had a very committed workforce, but there was a significant shortage of nursing staff which was compounded by additional wards being open.
- The trust was not complying with infection prevention and control standards.
- The trust performed better than expected in the number of patients acquiring clostridium difficile, however, they performed worse than expected for patients acquiring MRSA bacteraemia.
- Staff records regarding training showed poor performance in key areas such as infection prevention and control, safeguarding and moving and handling.
- The trust is failing to effectively assess and monitor the quality of care it provides.
- There were many areas where the trust was aware of the challenges and risks and had logged these risks on local and corporate risk registers, however, there were often no plans or measures for implementation for when the risks were going to be addressed or when changes had been made, including:
- The risk that child protection issues could be missed due to a failure to follow agreed processes had been identified, but not addressed;
- The risk of admitting children with high dependencies to wards that aren't appropriately staffed to meet their needs, has been on a risk register for over a year without being appropriately addressed; and
- There were risks identified with the management of the storage of anaesthetic drugs where changes had been implemented, but were not sufficient to manage the risks.

We saw several areas of good practice including:

- The effective management of 18 week referral to treatment times for patients.
- The specialist care for children with diabetes, specifically the outreach work into schools.
- A maternity triage care bundle to promote consistency of care provided for women.
- Announced and unannounced "skills drills" training to rehearse obstetric emergencies.
- Trainee doctors commented very positively on the support and mentorship they received while working at the trust.
- Good multidisciplinary team working to support one stop outpatient clinics.
- The critical care unit had a physiotherapy presence seven days a week, and undertook ward rounds each day, as well as being available on call.
- The trust had a proactive specialist nurse for organ donation.

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

The trust MUST

- Make sure it complies with infection prevention and control standards and that it monitors cleanliness against national standards.

Summary of findings

- Assure itself that the ventilation of all theatres meets required standards.
- Manage the risks associated with the numerous staffing establishment shortages across the trust.
- Make sure that staff are appropriately trained in safeguarding both adults and children, and that the trust regularly monitors and assesses the completion of actions agreed at weekly 'safety net' meetings.
- Make sure that all staff understand their responsibilities in relation to the trust's systems and processes that exist to safeguard children.
- Make sure staff are trained and understand their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Make sure that the use of keypads on wards does not unlawfully restrict patients' liberty.
- Make sure that all staff receive the full suite of mandatory training that is required to ensure patient safety.
- Make sure that there are adequate numbers of paediatric staff trained in Advanced Paediatric Life Support as per the Royal College of Nursing's recommended standard.
- Make sure of the effective operation of systems to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of patients.
- Make sure that local leaders are held accountable if they do not routinely and accurately complete required audits.
- Make sure that trust premises are secure and that maternity and children's areas and wards cannot be accessed by the public without staff knowledge and appropriate challenge when necessary.
- Make sure patients are protected against the risks associated with the unsafe use and management of medicines.
- Make sure patients and visitors are protected against the risks associated with unsafe or unsuitable premises.
- Make sure that equipment is properly maintained and suitable for its purpose and that out of date single use equipment is disposed of appropriately.
- Make sure that equipment is available in sufficient quantities in order to ensure the safety of patients and to meet their assessed needs.
- Make sure that records are accurately and appropriately maintained, are kept securely and can be located promptly when required.
- Make sure that early warning system documentation is appropriately maintained and that all staff react appropriately to triggers and prompts.

The trust should:

- Review the process for admitting patients to wards from the accident and emergency department to make sure the process is effectively managed and that unnecessary delays in transferring patients are not occurring.
- Review the resourcing of medical secretaries to make sure they can meet patient need and the trust's own targets for sending GP letters.
- Ensure there is a fixed rota for consultant cover out-of-hours for the critical care unit.
- Consider providing support from a Practice Nurse Educator for critical care nursing staff.
- Consider contributing to ICNARC data collection.
- Confirm the trust's permanent bed capacity and an accurate base staffing establishment figure the trust projects it needs to deliver safe and effective care for this number of beds.
- Engage with local end of life care leadership to establish the trust's strategy for the service.
- Make sure that appropriate translation services are available and are being utilised to meet patient need.

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 	There was an effective system for reporting and learning from incidents. The environment was regularly checked for hygiene standards, however, parts of the environment were not clean, despite audit scores indicating good levels of compliance. The Paediatric Early Warning Score (PEWS) system and National Early Warning Score (NEWS) system were used in the department to assess and respond to patient risk. The department did not give sufficient attention to ensuring children were safeguarded from abuse. Staff did not recognise or respond appropriately to make sure children were safeguarded. Training attendance was an average of 50% against a trust target of 80%. This was despite recent efforts to increase these levels. Staffing was approximately 25% below the trust's establishment levels, with regular nursing bank staff used to fill these shifts, and often staff from the department were doing extra shifts. The trust had recently increased the number of full-time consultants from four to eight by making four long-term locum posts substantive. The department was, however, still below its stated establishment of 12 consultant posts. All patients we spoke with told us that they were treated with dignity and respect by staff from ED. We observed staff treating people with dignity and respect in all interactions. Ambulance staff also fed back that they observed hospital staff maintaining people's privacy and dignity. Constraints on space affected the department's ability to be responsive to people's needs. There were patient confidentiality issues that had not been resolved. There was a lack of signage and a lack of information about treatment, conditions and what to expect in when visiting the ED. The booking-in process was confusing for some patients. Crowding in the department presented a major challenge. So far this year (2014 to 2015), 87% of attendances in the ED had been admitted, transferred or discharged within four hours. ED consultants were not able to admit patients to wards without the ward consultant's agreement.

Summary of findings

The department had a vision and strategy for its future, which included increasing the capacity of the department to meet the increased activity of the service. Redevelopment was already underway.
The department faced a number of present risks that had not been effectively mitigated. The environment had not been well maintained, despite the trust and department's leadership being aware of its condition. Infection control audits indicated that the environment was 100% compliant, despite a number of issues we found during our visit.
Trust and departmental leadership were also aware of privacy and confidentiality issues at the front desk, but little had been done to improve this.

Medical care

Requires improvement

Although we received mostly good feedback from patients, we had a number of concerns with the medical wards at the hospital. Many areas of patient safety did not mitigate evidence risks, such as staffing levels, equipment cleanliness, monitoring checks and the number of patients coming to harm.
Patient outcome performance was variable, with some areas reporting good results, but others were either poor or not reported at all at a local level. This inconsistency was also reflected in the following of national and local guidance across specialities.
Bed management was a major concern, with high bed occupancy and outliers (patients being cared for outside of the ward in which their condition is supposed to be managed) across the hospital. This meant that the medical leadership were reacting on a day to day basis to the service need, and plans to date had brought little improvement.

Surgery

Requires improvement

We found that there were insufficient staff on surgery wards and some nurse and healthcare assistant shifts were left uncovered. Medicines were not managed safely and the premises were poorly maintained. Patients did not have access to interventional radiology seven days a week. Elderly patients were not screened for dementia.
There was a long waiting list for a urodynamics study in the urology department and we observed

Summary of findings

			that beds on the day case unit were used for patients who were to stay overnight. Overall, systems were not sufficient to adequately ensure that service quality was monitored. We also noted that the hospital had consistently met the referral to treatment targets. Procedures used for reporting errors, incidents and near misses were effective. There was good communication between all staff involved in patient care and treatment. We observed that staff were caring and that all spoke respectfully to patients. Nurses and doctors were friendly and treated patients with compassion. Patients felt involved in decisions about their care and treatment.
Critical care	**Requires improvement**		Experienced and dedicated staff worked hard to ensure the unit was safe. Nursing and medical staffing levels were appropriate, although the rota for full specialist consultant cover was not complete out of hours. The unit had a high retention rate of experienced staff. Some of the routine safety checks were not being done, and there was a lack of local examination and display of patient harm data. Care and treatment was delivered by trained and experienced staff, and patients, relatives and trainee doctors spoke highly of the unit. There was input into patient care from many disciplines. Essential inputs into patient care such as pain relief and good nutrition and hydration were managed well. The unit did not conform to modern building standards and had a shortage of space. The facilities for patients and relatives were poor. Senior staff were committed to their patients, their staff and their unit. However, there was not enough reliable data or audit work to base decisions upon and drive the service forward. A lack of participation in a national audit programme meant data was not adjusted for patients' inherent risks, and the unit did not benchmark itself against other similar units to judge performance. There was, however, a strong culture of teamwork and commitment.
Maternity and gynaecology	**Requires improvement**		The trust had recognised the risk to safe and responsive care because of inadequate midwifery staffing. The staffing establishment had been

Summary of findings

increased and newly appointed midwives were expected to join the trust before the end of the year. At times of high activity current risk was mitigated by the use of the escalation policy to prioritise the needs of women in labour. This meant that other areas were sometimes short staffed.
Women were able to access antenatal and postnatal services near their home and high risk women were seen at antenatal clinics at the hospital. These clinics were sometimes crowded and women had to wait for appointments. There had been no evaluation of the reconfiguration of the community midwifery service to assess its effectiveness and staff told us they were under pressure. The business case to increase staffing had been agreed; the appointments had not been made at the time of our inspection.
The wards were kept clean, but infection-control procedures were not always followed. The storage of medicines did not comply with nationally recognised good practice.
There had been improvements to the effective use of the World Health Organization (WHO) surgical safety checklist in obstetric procedures. There was a high level of awareness about the importance of safeguarding women and babies.
Trainee doctors said the teaching and support from consultants was of a high standard. Midwifery staff took part in a well-established appraisal process and had opportunities for training and development. Staff were confident about the quality of care they provided, and this was reflected in the positive comments of women who used the service. Bereaved parents were well supported.
There was a systematic approach to clinical governance, which included a process for reviewing and investigating incidents, an audit programme and clear allocation of responsibility for reviewing guidelines.

Services for children and young people

Requires improvement

We found staff were dedicated, caring and compassionate and responded to children's needs. The staff worked well as a supportive team, learned from incidents and strove for effective patient care in sometimes difficult circumstances with insufficient staff and equipment, particularly on the children's ward.

Summary of findings

Although a number of issues had been identified as risks, action to reduce the level of risk had not been a demonstrable priority for management. This meant that there was a failure to mitigate known risks and as well as the inherent risks to children, this also led to evident frustration amongst staff. Outcomes for patients were generally good and treatment was in line with national guidelines and there were clear strengths in specialist areas in treating both neonates and children. However, there was no overarching vision of where the service hoped to be in the years ahead. There was a limited approach to involving either staff at all levels or those who used the services for children and young people, or staff at all levels in planning for change.

End of life care

Requires improvement

The SPCT hoped that the newly appointed committee and the recent appointment of a board director lead would increase the visibility of end of life care (EOLC) in the hospital. They said this would ensure that appropriate and consistent EOLC was provided to patients by all staff across the hospital and not be seen as the sole responsibility of the SPCT.

The SPCT talked passionately about future aspirations to bring patient's EOLC to the forefront of staff minds and to develop integrated care pathways that involved community services such as nursing, palliative care, GPs, ambulance, hospices and care homes, to frail and older patients, and those dying through complex health issues. It was hoped that this would decrease the number of unnecessary admissions to the hospital.

We saw that there were regular ward and SPCT MDT meetings to discuss patients who had been recognised as dying. The trust had developed, but not implemented end of life guidance to replace the Liverpool Care Pathway. The completion of 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms was variable and the documentation of mental capacity assessments was inconsistent.

All the staff involved in end of life care were passionate, caring and maintained patients' dignity throughout their care. Relatives told us they were supported and felt informed at all times. One relative described the care as "outstanding".

Summary of findings

The SPCT did not have the resources to provide support to patients seven days a week, however there was an out of hours on-call system. Hospital staff reported they felt able to request support from the SPCT whenever it was required. The SPCT usually responded within 24 hours. 60% of the patients supported by the SPCT were non-cancer patients. This showed a good balance between cancer and non-cancer patients being provided with the specialist services from the palliative care team.

There were no dedicated palliative care beds at the hospital and it was not always possible to care for people at the end of their life in a side room. There were very few rooms in the hospital for private conversations to be held. The SPCT were able to arrange rapid discharge for people who wished to die in a different location. They also had access to dedicated palliative care beds in a local nursing home.

There was no trust EOLC policy or strategy. Staff reported there had been very little senior management engagement until the very recent appointment of a board director. There were limited governance systems although some audits had taken place. Action plans had been developed but there was no evidence of changes being implemented. We did find some examples of good leadership, especially within the SPCT. Ward based staff were committed to providing high quality care for patients at the end of life.

Outpatients

Requires improvement

We found that letters to general practitioners (GPs) were not being sent within the five-day period in line with trust policy. On the day of our inspection, the majority of medical secretaries were not typing letters within this timeframe.

The renal outpatients department (OPD) was unable to provide patients with follow-up appointments in a timely manner.

The ophthalmology clinic was not an ideal environment, as it was too small to meet with the demands of the service. Although the trust had attempted to mitigate the issue by running extra clinics within the community, this issue was still evident at the Hillingdon Hospital site.

Summary of findings

The trust was very responsive when planning the service to meet the needs of local people. Effective consultation allowed the service design to meet the needs of local communities and staff groups. We saw good ownership of the care and treatment they delivered by staff of all grades.

A proactive stance was taken in addressing issues that impacted on care delivery, such as developing a policy to monitor and reduce non-attendance at hospital appointments. In general, resources and facilities were good and met the needs of people attending the department.

We found that the OPD was accurately monitoring patient pathways. The central booking service was consistently able to give patient appointments within the NHS England and Clinical Commissioning Groups 2012 regulations about 18-week referral-to-treatment targets. We were able to see evidence of clear strategies to monitor and maintain systems to ensure that the trust met with these targets. The trust was consistently meeting with the two-week wait timescale for patients with urgent conditions, such as cancer and heart disease. We were able to see evidence of clear strategies to monitor and maintain systems to ensure that the trust met with these targets.

We found good local leadership within the OPD departments. The OPD matron was praised highly by staff who felt that they were proactive and supportive.

Requires improvement

Hillingdon Hospital

Detailed findings

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

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Detailed findings

Background to Hillingdon Hospital

The current Hillingdon Hospital opened its doors in 1967 and the trust was awarded foundation status in April 2011. The trust employs over 2,500 staff.

The trust provides services to the residents of the London Borough of Hillingdon, and increasingly to those living in the surrounding areas of Ealing, Harrow, Buckinghamshire and Hertfordshire giving them a total catchment population of over 300,000 people.

Hillingdon is a diverse suburban borough, with a large young population and an increasing proportion of older people. 25% of the population is under 18 years of age, while the proportion aged over 85 is set to rise by 22% by 2020. The proportion of the population from an ethnic background has risen to 28% of the total, and is projected to rise to 37% in 2020.

Hillingdon is the nearest district general hospital to London's Heathrow Airport, the busiest airport in Europe in terms of passenger numbers.

Our inspection team

Our inspection team was led by:

Chair: Mark Pugh, Executive Medical Director, Isle of Wight NHS Trust

Head of Hospital Inspections: Siobhan Jordan, Care Quality Commission (CQC)

Inspection Manager: Damian Cooper, CQC

CQC inspectors were joined on the inspection team by a variety of specialists including a student nurse and junior doctor, consultants in emergency medicine, obstetrics, intensive care medicine and paediatrics, experts by experience, an associate medical director, a consultant nurse for older people, a consultant midwife, clinical nurse specialists and estates and facilities advisers.

How we carried out this inspection

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

• Is it safe?

• Is it effective?

• Is it caring?

• Is it responsive to people's needs?

• Is it well-led?

The announced inspection visit took place between the 1 and 3 October 2014, with subsequent unannounced inspection visits on 15 and 16 October.

Before visiting, we reviewed a range of information we held, and asked other organisations to share what they knew about the hospital. These included the clinical commissioning group (CCG); Monitor; NHS England; Health Education England (HEE); General Medical Council (GMC); Nursing and Midwifery Council (NMC); Royal College of Nursing; College of Emergency Medicine; Royal College of Anaesthetists; NHS Litigation Authority; Parliamentary and Health Service Ombudsman; Royal College of Radiologists and the local Healthwatch.

We held a listening event on 30 September 2014, when people shared their views and experiences of

Hillingdon Hospital. Some people who were unable to attend the listening event shared their experiences with us via email or by telephone.

During our inspection we held focus groups with a range of hospital staff, including support workers, nurses, doctors (consultants and junior doctors), physiotherapists, occupational therapists and student nurses. We talked with patients and staff from all areas of the hospital, including the wards, theatres, outpatients,

Detailed findings

maternity and the emergency department. We observed how people were being cared for, talked with carers and/ family members and reviewed patients' personal care or treatment records

We would like to thank all staff, patients, carers and stakeholders for sharing their views and experiences of the quality of care and treatment at Hillingdon Hospital.

Detailed findings

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

1. We are currently not confident that we are collecting sufficient evidence to rate effectiveness for both accident and emergency and outpatients.
2. The rating of requires improvement overall for accident & emergency is a deviation from our principles of aggregation. This is because effective is not rated.
3. We have issued the trust with a warning notice for a breach of regulation 10 of the Health and Social Care Act Regulated Activities Regulations 2010. Regulation 10 governs 'assessing and monitoring the quality of service provision' which relates to the well-led domain. This enforcement action is a deviation from our published guidance which sets out that we would, usually, only issue a warning notice for a breach of regulation 10 if a well-led rating for any core service was rated inadequate.

Urgent and emergency services

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

Information about the service

Hillingdon Hospital's emergency department (ED), also known as the accident and emergency (A&E) department, saw approximately 85,000 patients in 2013. The department consisted of a major treatment area, an assessment area, resuscitation area and separate paediatric ED.

The department was originally designed and built to provide for attendance numbers of 50,000 patients a year. So far for 2014, indicators showed that attendances would exceed the previous year's attendance figure by 10%. This meant that in 2014, the department would see almost double the number of patients than the building was designed to accommodate in the period.

The initial assessment / triage of all walk-in patients was undertaken by another provider, the urgent care centre (UCC) which was based within the hospital's main ED area. Once assessed by the UCC, patients would either remain under the care of the UCC service for further treatment, or would be referred to the ED.

Summary of findings

There was an effective system for reporting and learning from incidents. The environment was regularly checked for hygiene standards, however, parts of the environment were not clean, despite audit scores indicating good levels of compliance. The Paediatric Early Warning Score (PEWS) system and National Early Warning Score (NEWS) system were used in the department to assess and respond to patient risk.

The department did not give sufficient attention to ensuring children were safeguarded from abuse. Staff did not recognise or respond appropriately to make sure children were safeguarded.

Training attendance was an average of 50% against a trust target of 80%. This was despite recent efforts to increase these levels. Staffing was approximately 25% below the trust's establishment levels, with regular nursing bank staff used to fill these shifts, and often staff from the department were doing extra shifts. The trust had recently increased the number of full-time consultants from four to eight by making four long-term locum posts substantive. The department was, however, still below its stated establishment of 12 consultant posts.

All patients we spoke with told us that they were treated with dignity and respect by staff from ED. We observed staff treating people with dignity and respect in all interactions. Ambulance staff also fed back that they observed hospital staff maintaining people's privacy and dignity.

Urgent and emergency services

Constraints on space affected the department's ability to be responsive to people's needs. There were patient confidentiality issues that had not been resolved. There was a lack of signage and a lack of information about treatment, conditions and what to expect in when visiting the ED.

The booking-in process was confusing for some patients. Crowding in the department presented a major challenge. So far this year (2014 to 2015), 87% of attendances in the ED had been admitted, transferred or discharged within four hours. ED consultants were not able to admit patients to wards without the ward consultant's agreement.

The department had a vision and strategy for its future, which included increasing the capacity of the department to meet the increased activity of the service. Redevelopment was already underway.

The department faced a number of present risks that had not been effectively mitigated. The environment had not been well maintained, despite the trust and department's leadership being aware of its condition.

One recent audit in August 2014 had found the environment to be 100% compliant, yet a number of other recent audits in July and September 2014 had found the environment to be no more than 88% compliant. We found a number of issues during our visit which showed that the environment would not have achieved 100% compliance.

Trust and departmental leadership were also aware of privacy and confidentiality issues at the front desk, but little had been done to improve this.

Are urgent and emergency services safe?

Inadequate

There was an effective system for reporting and learning from incidents. The environment was regularly checked for hygiene standards, however, parts of the environment were not clean despite audit scores indicating good levels of compliance. The Paediatric Early Warning Score (PEWS) system and National Early Warning Score (NEWS) system were used in the department to assess and respond to patient risk.

Training attendance was an average of 50% against a trust target of 80%. This was despite recent efforts to increase these levels. Staffing was approximately 25% below the trust's establishment levels with regular nursing bank staff used to fill these shifts, and often staff from the department were doing extra shifts. The trust had recently increased the number of full-time consultants from four to eight by making four long-term locum posts substantive. The department was, however, still below its stated establishment of 12 consultant posts.

The corporate risk register showed a medium risk that some vulnerable young people were not being identified in the ED, and incidents had been reported where vulnerable children had not been identified. The statutory post of a named nurse for safeguarding, which all trusts must have, was vacant, and was not due to be filled until January 2015.

Incidents

- In the last year and a half (since April 2013), there had been two serious incidents requiring investigation and one never event. Never events are serious, largely preventable patient safety incidents, which should not occur if the available, preventable measures have been implemented.
- Different grades of staff were able to tell us about these incidents and what action had been taken as a result of these investigations, to protect people in the future. This included the paediatric emergency department now keeping Buccal midazolam and Lorazepam for children having seizures. These drugs had previously only been available on resuscitation trolleys.
- Incidents were usually investigated by the nurse consultant for the ED, or the ED matron.

- Monthly clinical governance meetings within the department reviewed incident investigations and looked at themes and issues arising from incidents. An incident report was prepared for the meeting which drew out themes from all incidents that had been reported within the department. The report also identified which location within the department the incident had occurred for further analysis.
- Lessons learned from incidents were communicated to staff at shift handovers. We were also shown examples of memos sent out to staff that reported on incident outcomes.
- Governance leads for the trust reported on incidents to staff in a trust-wide monthly newsletter, which had been introduced a month before our visit.
- We were told by the ED matron that everyone was encouraged to report incidents, although this would usually fall to key members of staff, such as shift leaders and managers.
- The matron told us the department was good at reporting pressure ulcers and the department's monthly incident report demonstrated a high level of incidents had been reported for patients "admitted with a pressure ulcer". Established assessments of skin integrity (Waterlow assessments) were only carried out on patients who were to be admitted. Other assessments and documenting of any pressure sores were reported as incidents. We saw an example of this, where a category four pressure ulcer (the most serious category) was reported as an incident and automatically alerted the safeguarding adult lead and tissue viability nurse.
- The incident report indicated a high number of patients absconding. We were told that patients awaiting a mental health or Mental Health Act assessment waited in the main waiting area, due to the lack of space within the department and that this was a contributory factor.
- The risk register was reviewed at the leadership meeting for the medical division. It showed recognised delays in mental health assessments, medical staff not completing discharge summaries in a timely manner and no on-site, out of hours radiographer.

Cleanliness, infection control and hygiene

- Hand sanitising gel, soap dispensers and gloves were available throughout the department and staff observed good hand hygiene. However, doctors were not always following trust policy of being 'bare below the elbows'.
- The resuscitation area was reasonably clean and tidy. Personal protective equipment such as gloves were available, however, we did not see aprons readily to hand, and staff were not wearing aprons. This was the same in the assessment area. There were sinks, soap, hand towels and hand gel. The sharps bins were labelled with the area (ED) and dated, and none of them were over full. The areas were clean, but needed decorating as there was chipped plaster and paint that were presented a potential infection control risk.
- We observed a quick and efficient turnaround for cleaning beds in cubicles in preparation for the next patient.
- There were monthly infection control audits taking place. Results were displayed in the department. These showed 100% compliance on hand hygiene and environmental audits. Staff training on infection prevention and control was at 50%. We were told the trust target was 92%.
- We observed a number of environmental hygiene issues, indicating the department would not achieve 100% compliance against audits. We observed a urine-stained commode in the clinical decisions unit (CDU). The label indicated it had been cleaned the day before.
- Radiator grills in clinical areas were visibly covered with grime, which indicated they had not been cleaned for a while. There was dust inside them. There were two bays in the CDU for the specific use of children, but they were also used as an overflow when the unit needed more capacity. The window frames had duct tape around them to cover gaps. There was also dust and dirt on the window sill. The window blind was discoloured by grime. There was a build-up of dust on curtain rails.
- Some of the fabric curtains around the bed spaces in the paediatric observation unit were not dated, although we were told there were measures in place to ensure that curtains were replaced at appropriate intervals.
- Some items in the paediatric ED area were labelled clinically clean but seen to be dirty. We saw the same sticky tape marks on a small trolley for small items of equipment outside the two-bed observation area for three days in succession. The front of a bedside cabinet in the observation area had dirty marks, apparently from fabric-strapping tape. A dusty suction machine was seen in one cubicle.

- We saw a parent washing a small child who was suffering with diarrhoea in a hand-wash sink beside a cubicle in paediatric ED. No staff intervened.

Environment and equipment

- The size and layout of the ED presented challenges to safety because of the high number of patients seen. This was widely acknowledged by the trust leadership as a challenge. We were told this was further exacerbated by the lack of beds within the hospital and staff being taken out of the department to hand patients over to wards.
- A consultant reported to us that there had been as many as 68 patients in the department at one time, with only 13 cubicles. This had meant that patients were sometimes cared for in corridors and around the "racetrack" area (major treatment area) rather than in cubicles.
- We observed a variety of maintenance issues that had not been resolved. Skirting tiling was missing in some places, which exposed bare brick. Panels were missing in some patient cubicles. There was a piece of metal protruding out in to the entrance to the major treatment area. There was cracked and broken floor tiling and lino in many areas, much of which had been covered over with duct tape.
- In the A&E eye room, a basin with shower attachment was provided for the irrigation of eyes. The frequency of use of this attachment was unknown, but was likely to be infrequent. The shower hose was not fitted with an anti-stagnation valve which meant the water was able to lie within the hose and stagnate. We raised this with the trust immediately due to the high risks associated with stagnant water. We were told that the trust had been experiencing difficulties with water quality and has recently held an extraordinary water safety management group meeting.
- A balustrade / guard rail was provided to the ramp and turnaround area immediately outside the A&E department to prevent vehicles falling off. The design of this balustrade consisted of a number of vertical supports with two horizontal rails. This was part of the main entrance to the A&E department and it was a public access area and could be accessed by children under five years old. The building regulations require that guarding in areas that are likely to be used by children less than 5 years old must be capable of preventing a 100mm sphere to pass through. The opening between these rails was significantly in excess of 100mm.
- The matron told us they felt the department had an acceptable amount of equipment, which had recently been increased. Four electrocardiogram (ECG) machines and an ultrasound machine. Fast scans could be done within the department instead of referring to a speciality. The matron felt that faulty equipment was repaired quickly by contractors.
- The trust's nursing lead, with overall management responsibility for the department, told us they were aware of recent equipment issues and had acted on this. New ECG machines and portable ultrasound machines had been purchased for the department.
- There were 15 cubicles in Majors, but only eight with monitors. None of these monitors provided a printout for staff to be able to carry out continuous observation on patients.
- Staff told us there was sufficient equipment available in the assessment area and the administrator showed us how faults were reported and logged. The bioengineering manager told us equipment was rarely taken away from a department and was usually repaired on site to reduce delays if possible.
- Staff told us that equipment was usually returned the same day and the log book confirmed this. Staff in the resuscitation room also told us that there was sufficient equipment available. They told us that ECG machines broke down quite often, but they were able to borrow from other areas, such as Majors. Each bay had infusion pumps available, which were cleaned by staff in between usage.

Medicines

- Controlled drugs were stored securely but not regularly checked. There were gaps in the checks made on the mobile resuscitation trolley located near to the assessment area. On 17, 18, 20, 23 and 26 September 2014, checks did not occur. There were similar gaps for July and August 2014 and a large gap between 15 and 25 July 2014.
- The trolleys had not been checked regularly in the resuscitation area. Paediatric resuscitation equipment

had also not been checked regularly. There were gaps in checks on oxygen cylinders. Also, the adult difficult intubation / airway trolley had last been checked on 31 July 2014.
- The resuscitation trolley had been checked daily in the major treatment area.
- Generally, there were gaps in other daily checklists for minor and major treatment areas. Checking on equipment, such as clinical stock and chest drain kits had not been completed.
- Drug fridges were unlocked and temperature checks had not been completed in some areas including Majors.
- In resuscitation, we found drawers with intravenous drugs, such as Atropine and adrenaline had been left open. This was in an unsupervised area to which patients had access.
- All the drug cupboards in the resuscitation area were locked and keys were held by the nurse in charge.
- We saw on two occasions, staff checking medication to give to patients (analgesia and heparin) - on both occasions, the correct two-nurse checking procedure was followed.
- Resuscitation drugs in the resuscitation area were sealed and in date, with blue tags for adult and red tags for paediatric. The controlled drugs book was checked twice daily by staff and by pharmacy and no errors were found.
- The paediatric medication guidelines were up to date and appropriate, although staff were unclear about who was responsible for conducting the drug challenge protocol to detect allergies.

Records

- Paper medical records had recently been moved off site for storage. This had caused issues with obtaining sets of notes. Due to staff complaints and issues being escalated, this had been improved. The casualty cards were scanned into an electronic system, so this information was always available.
- There was a conflict with data systems. The patient administration system was used to book patients in and ED staff checked on this system to find out if patients were already known to the hospital. This gave basic information, such as when patients had visited. More detailed information was held on 'Datastore'. This system held scanned casualty cards, treatment records and medication administered.
- Other departments within the hospital used other systems. For the ED department, there was the potential to have to gather patient information from four systems. The nurse consultant told us there was a new IT lead employed by the trust. Their role included improving the current system.
- Staff told us that the UCC and trust computer systems were not able to talk to each other and, therefore, patient data stored on either system could not be viewed by the other provider.
- Notifications were sent electronically to GPs within four hours of attendance at ED.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- The child and adolescent mental health services were not available out of working hours, so children who needed a mental health assessment had to be admitted to the children's ward. There they would stay with an agency-registered mental health nurse until an assessment was arranged.
- We heard staff asking for a child's consent to examine or treat them.
- Staff we spoke with told us they had not had training on the Mental Capacity Act 2005, or best interests decisions.

Safeguarding

- The corporate risk register showed a medium risk that some vulnerable young people were not being identified in the ED. We saw a recent example of an incident where an obviously vulnerable young teen had not been identified as such until they presented again at the ED. Several hospital staff would have spoken with this young person (who had been brought in from the police station), between arrival and discharge yet no one had recorded any safeguarding concerns.
- The statutory role of named nurse for safeguarding was vacant and would not be filled until January 2015. The three-month gap was being covered through additional consultant oversight, but this did not include the training role of the named nurse. Two doctors shared the named doctor role for safeguarding.
- Potential safeguarding cases were referred to the paediatric liaison health visitor whose role was part-time. Reception desk staff were responsible for checking the child protection status of children coming into the department and annotating their files. Several staff in different roles expressed a concern that

information from local authorities was not always kept up to date. Staff we spoke with were aware of safeguarding issues, both in relation to children and vulnerable adults, and knew how to report them.
- Notes of all potential safeguarding cases were reviewed at a monthly meeting. Staff were aware of possible trafficking issues, because of the hospital's proximity to Heathrow airport, but said such cases were hard to pick up.

Mandatory training

- Core training topics included basic and advanced life support, advanced trauma support, conflict resolution, equality and diversity, infection control and safeguarding children. Training figures for the department showed that the trust target of 80% attendance had not been achieved in any subject. Infection prevention and control level 2 was 52%, safeguarding adults 51% and conflict resolution 50%.
- We were told that the department had made efforts recently to improve these statistics as they had been even lower. The assistant director of nursing told us the department went from 22% to 48% attendance rate for level 3 safeguarding training in three months.
- The nurse consultant told us that releasing people off the floor to attend training was a challenge, due to the pressure there was on the department.

Assessing and responding to patient risk

- The initial assessment / triage of patients walking into the department was undertaken by another provider; the UCC, whose reception was based within the hospital's main ED area.
- UCC reception was staffed by two receptionists and a nurse practitioner. Patients either saw the nurse first for assessment, or, if the nurse was busy, patients were booked in by the receptionist to wait.
- Once assessed by the UCC nurse, patients were signposted to the UCC's GPs, or onto the hospital's ED department. It was not clear how the people attending knew who they were waiting to see, or how long the wait would be for any of the services.
- Staff told us that if people asked they would estimate by the number waiting to be seen in front of them. We witnessed staff being polite and professional at all times when communicating with patients.
- Staff at reception told us they informally kept an eye on patients waiting and informed staff if they were concerned. We observed that patients did not wait more than 20 to 30 minutes for a nurse assessment.
- All patients had a clinical assessment by a nurse practitioner and all patients attending ED were assessed by a nurse.
- A consultant saw every patient on arrival to the department by ambulance where a handover took place. The presenting condition was documented, a plan of care and investigations were initiated.
- All patients received were risk scored in the assessment area to detect if their conditions deteriorated.
- The paediatric ED had introduced the Paediatric Early Warning Score (PEWS) system and ED were using the National Early Warning Score (NEWS) system.
- Assessment booklets used in the ED included nutrition screening, falls assessment based on Royal College of Physicians recommendations, and skin assessment. Nursing staff in the major treatment area told us it was standard procedure for documentation to only be commenced once a decision to admit to either a ward or the clinical decision unit had been made.
- There was a white board in the major treatment area that provided information such as name, NEWS and risk score.
- On arrival for our evening visit, there were 11 patients in Majors, nine of which had NEWS results and only one of these required regular observations, which were occurring.
- There was a London Ambulance Service (LAS) computer that told staff what patients were coming in and the approximate times that LAS had left the pick-up point. It showed in bright bold blue text that there was an emergency coming in. This generally showed prior to the emergency phone call received from LAS, so enabled staff to plan and allocate staff to receive the emergency.
- In a resuscitation bay, we observed one patient brought in from Heathrow and treated promptly. The patient arrived at 10:50pm by ambulance and was seen immediately, treated and was waiting to go to the ward after having a CT scan, and left at 12:20am.
- Observation was carried out using NEWS and was completed every 30 minutes, as prescribed, as well as being risk assessed. Prior to leaving, they were risk assessed as 'stable' and the risk was downgraded to 'amber'. Observations changed to four per hour.

- We were shown a chest pain and maternity pathway / protocol that directed patients to the hospital's ED department. All adult mental health assessments were dealt with by a mental health liaison nurse based in hospital's ED department and provided by a local mental health trust.
- There were rapid assessment processes for children admitted by ambulance.
- In the paediatric ED we looked at seven sets of notes. Only one set was complete. Three sets of notes contained no baseline observations. In another set, the NEWS results had not been totalled. In a third, where a score of three should have prompted half-hourly observations, the next observation was two and a half hours later. That score was not recorded on the back of the chart, as the guidelines stated. There were no triage notes.

Nursing staffing

- The department was approximately 25% down on staff numbers. There were six band 7 nurses out of an establishment of eight, 15 band 6 nurses out of an establishment of 20, and 23 band 5 nurses out of 27.
- We were told that the department lost two emergency nurse practitioners last year, when the UCC was established. They were recruited by the new service. One band 7 and two band 6 nurses had also been recruited by the UCC. Replacing nurses had proved difficult and the band 7 post had not been recruited.
- The nurse consultant for the department told us they had recruited eight registered nurses this year; six band 5 nurses and one band six nurse. Also one paediatric lead and two healthcare assistants.
- 70% of bank staff shifts were covered by ED staff. Agency shifts were covered by an agency able to supply experienced ED staff.
- The trust's nursing and medical leads told us that when the acute medical unit becomes operational in December 2014 and its practice was embedded, they would look again at the staffing needs of the department.
- During discussions with trust staff at all levels, there was no evidence or demonstration that the department had considered and projected the vacancies they would have across service provision when the acute medical unit was operational. Staffing needs were only talked about in the present.
- Until recently, the paediatric ED had only two paediatric trained nurses, but there were now paediatric trained staff on every shift. One newly qualified nurse had started and told us about a comprehensive induction undertaken over a two-week period while supernumerary. We noted, however, this nurse had no triage training and was not supervised while doing triage.
- New nursing staff would rotate through the paediatric ED and the paediatric wards every six months.
- Three other nurses were due to start shortly, but two posts remained vacant. There were sometimes nurses without paediatric training in the department. However a ring-fenced rota for the paediatric ED had been agreed in April 2014, when a new nursing lead started. This maximised paediatric trained cover.

Medical staffing

- There was consultant cover for the department between 8am and 10pm, Monday to Friday, and 9am to 8pm at the weekend. Consultant cover was available on call outside of these hours. Two staff-grade doctors and two junior doctors were on duty overnight.
- The department had recently increased the number of permanent consultants based in the department from four to eight by making four long-term locum posts substantive. This left the department four short of their stated establishment of 12.
- There was good consultant visibility on the floor to support senior decision making.
- The paediatric ED was staffed by the paediatric service, because staffing was shared across the paediatric services. There was consultant paediatrician oversight, shared between three paediatricians, until 8pm Monday to Friday, but not always a consultant in the department.
- Staff had some concerns about night-time cover when one registrar covered the paediatric department, neonatal unit and the paediatric ED, because geographically the units were far apart.

Major incident awareness and training

- There was a trust emergency planning officer on site. A major incident folder detailed roles and responsibilities in the event of a major incident. The coordination of the ED department and roles of middle grade nurses.
- We were given examples of incidents that the department had dealt with that included a major traffic accident on the M4 and responding to incidents at

Heathrow airport. In these events, rooms within the department were allocated for use, doctors were allocated to senior decision-making roles and public health bodies were contacted.
- Audits of facilities, equipment and training to deal with major incidents took place following any events.
- There had been a practical exercise within the department in preparation to deal with taking patients with Ebola. This had involved allocation of rooms, equipment, decontamination and transportation.

Are urgent and emergency services effective?

(for example, treatment is effective)

Not sufficient evidence to rate

The department used National Institute for Health and Care Excellence and College of Emergency Medicine guidelines to determine the treatment they provided.

The trust took part in a number of national audits that were directly related to the care and treatment of patients in ED and implemented changes based on audit results.

There was a new appraisal process based on the trust's 'CARES' values; compassion, attitude, responsibility, equity and safety. Responsibility for conducting and completing annual appraisals was cascaded through the staffing grades and around 94% had been completed.

There was an induction period for all newly recruited staff. Staff competency was assessed during this period.

Pain relief was given on arrival in the department. However, there was no routine checking of pain or comfort once assessed. Nutrition and hydration checks were not documented while patients waited in the department.

Evidence-based care and treatment

- The department used National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. This included fractured neck of femur NICE guidance and CEM guidance on treatment of conditions.
- The paediatric ED had introduced the Paediatric Early Warning Score (PEWS) system and the ED were using the National Early Warning Score (NEWS) system.
- Assessment booklets used in the ED included nutrition screening, falls assessment based on Royal College of Physicians recommendations and skin assessment.
- We did ask the service for information related to local audit activity, but did not receive this information.

Pain relief

- We observed examples of several patients coming in via ambulance and pain relief was administered promptly, for a variety of issues, such as back pain, abdominal pain and fracture.
- In the resuscitation area, pain relief was given. Observations were done every 30 minutes.
- In the major treatment area, patients had been triaged and assessed and initial treatment had taken place that had included pain relief. However, there was no evidence to support that nurse rounds to check on pain management or comfort after assessment happened as there were none documented.
- We observed and spoke to people in the assessment area who told us that they had been offered and given analgesia as part of their assessment.
- ED staff used paediatric pain assessment charts, sometimes pictorial and sometimes a verbal score from one to 10.

Nutrition and hydration

- Care-planning documentation was only commenced once a decision to admit to a ward or the clinical decisions unit had been made. This was observed in practice and described by the sister in charge. One patient had been in the department for four hours. There had been no nutrition or hydration checks documented.
- Patients in the major treatment area with a requirement for fluid rehydration were commenced on a fluid chart. At regular meal times the kitchen assistant from the CDU attended the majors area; the nurse in charge identified patients requiring food which was identified as a small green dot on the whiteboard.
- There were vending machines in the main waiting area for drinks and snacks. A café was located a short distance from the department.

Urgent and emergency services

Patient outcomes

- The trust took part in a number of national audits that were directly related to the care and treatment of patients in ED. This included the CEM Severe Sepsis and Septic Shock Clinical Audit 2013/14, CEM Clinical Audits in fractured neck of femur and renal colic 2012/13 and Feverish Children 2010/11.
- Action plans had been developed in relation to the findings and progress on actions had been documented. Improving recording of observations / vital signs in response to the Feverish Children audit and developing a joint protocol with UCC for early identification in response to the Severe Sepsis audit.

Competent staff

- There was a new appraisal process based on the trust's 'CARES' values; compassion, attitude, responsibility, equity and safety. Responsibility for conducting and completing annual appraisals was cascaded through the staffing grades and around 94% had been completed.
- There was an induction period for all newly recruited staff. Staff competency was assessed during this period. We were given a recent example where a support package had been implemented in order to further develop one new starter's competency.
- There were local inductions for both bank and agency staff in the form of worksheets intended to familiarise the department to new staff, such as who to report to and where things were kept and stored. These worksheets were put in the daily folder in advance of the arrival of the new nurse.
- There was an expectation that all band 6 nurses and above completed the mentorship course, a teaching qualification within the department to mentor student nurses.
- There was an orientation programme within the department that lasted for two weeks and included spending time in different areas of ED, and seminars from medical specialities.
- Two sisters were currently studying for an advanced nurse practitioner's course. This was a one day a week, three term course at a local university. It was funded by the trust, but done in the nurses' own time, i.e. on days off, or leave days. There was also a four-month ED course for nurses, which was delivered one day a week. 100% study leave was given for this.
- Nurses and students told us they felt well supported by senior staff. Junior doctors also told us they felt well supported by seniors.
- A nurse consultant told us it was a priority to ensure that nurses got on to an emergency nurse clinical course. They had spaces for seven per year and one paediatric specialist course this year; four in February and four in September, each were six months in duration.
- Doctors told us that middle grade doctors had regular monthly protected teaching time and were supported to attend courses and take study leave.

Multidisciplinary working

- Key staff from the emergency assessment unit attended an ED board round at midday every day. This was to assist patient flow by admitting appropriate patients directly if there was bed space.
- Bed meetings were attended by ED staff. Internal ward rounds were carried out throughout the day by the lead consultant and registrar.
- Attendance at departmental multidisciplinary team meetings had not been fully attended. We were told this was because attendance was in addition to shifts. Attempts had been made to attach shifts onto meetings, so people were not travelling in especially for the meetings.
- Emergency task force meetings were held weekly. This involved the bed management team, commissioners, social services, anyone who was specific to patient flow and the improvement of the patient journey.
- Psychiatric liaison was provided by a mental health nurse based on site, from a local mental health trust. Weekly liaison meetings took place with ED managers. Staff reported delays in mental health assessments when a psychiatrist was requested to attend and when a Mental Health Act 1983 assessment was required.
- The lead nurse for the department told us they had good working relationships with the UCC based on site and managed by a different service provider, and that regular meetings took place Referrals could be made to drug and alcohol services, or the child development centre.

Seven-day services

- There was consultant cover for the department between 8am and 10pm Monday to Friday, and 9am and 8pm at the weekend. Consultant cover was available on call outside of these hours. Two staff grade doctors and two junior doctors were on duty overnight.

Urgent and emergency services

- There was no on-site, out-of-hours radiographer. This was assessed as an 'amber' (medium) risk on the trust's risk register. The control in place was for the consultant to contact the radiologist at home in an emergency.
- There was an on call mental health liaison service available out of hours.

Are urgent and emergency services caring?

Good

All patients we spoke with told us that they were treated with dignity and respect by staff from the ED. We observed staff treating people with dignity and respect in all interactions. This was also reported to us by ambulance staff.

Compassionate care

- We spoke with numerous people who had interacted with the service, including patients, their relatives and ambulance staff. Every one we spoke with told us they felt that care and treatment was given in a kind and respectful way. One patient told us, "I have been using a wheelchair for a couple of years now. I come here a lot. Despite the long waits, I always find staff treat me with respect. They have always been good to me."
- Another person told us they had visited the department with their elderly father from a care home. They said of staff: "they were fine with my father and me. They treated the both of us with dignity and respect and I think they do a good job."
- Ambulance crew told us they thought the staff were the most helpful and friendly of the ones visited in the course of their work. "We are happy to use this hospital," we were told.
- We observed staff at the reception desk dealing with a busy reception. We observed that staff dealt with people quickly and efficiently and were kind and respectful.
- From November 2013 to April 22014, the trust scored the same as or above the England average for the NHS Friends and Family Test results for A&E departments.
- The ED leadership told us that constraints on space made some practices that might breach confidentiality or compromise privacy an unfortunate inevitability. On many occasions throughout our visit we observed patients giving personal details, such as address and phone number, as well as if they were using medication – details that were easily overheard by people in the busy waiting area.

Patient understanding and involvement

- Parents commented positively on the knowledge of the staff treating their children.
- The Adult Inpatient Survey, conducted by the Care Quality Commission in 2013 showed that the ED department had scored about the same as other trusts regarding patients being given enough information on their condition and treatment, but scored below the England average when patients were asked "were you given enough privacy when being examined or treated in the A&E department?".
- We heard staff introducing themselves to patients and explaining procedures they were carrying out.
- Patients told us that they felt staff provided enough information regarding their care and treatment. One patient said: "the doctors treated me well. They were quite nice," while another patient told us that the kindness of staff was the reason they felt the department worked well for them.
- However, people also told us that they were not given enough information regarding what would happen once they had been booked in at the main reception and would not know anything until they were called, sometimes hours later.

Emotional support

- We observed staff being sensitive to patients who were visibly upset or anxious.

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

(for example, to feedback?)

Requires improvement

Constraints on space affected the department's ability to be responsive to people's needs. There were confidentiality issues that had not been resolved. There was a lack of visual signage and a lack of information about treatment, conditions and what to expect from visiting the ED.

The booking-in process was confusing for some patients. Crowding in the department presented a major challenge. So far this year (2014 to 2015), 87% of attendances in the ED had been admitted, transferred or discharged within four hours. ED consultants were not able to admit patients to wards without the ward consultant's agreement.

Service planning and delivery to meet the needs of local people

- We were told that the amount of space given over to the UCC when the service became operational last year had meant the ED faced a further challenge from the amount of space available to them. This was because, at the time, it was envisaged that the UCC would also be taking a large proportion of activity from ED. Given the increase in numbers visiting the department, this had not transpired.
- We spoke to the medical and nurse leads for the trust, those with management responsibility for the ED department, about the premises size for the number of people coming through the door. They told us they were aware of its limitations. There was a plan for a new acute medical unit to become operational in December 2014, providing 46 beds. This would adjoin the ED and replace the 14 bed emergency assessment unit which was currently located on the fourth floor.
- There were also plans to reconfigure and enlarge both the paediatric ED space and the major treatment area, which would be completed in December 2015 and December 2016, respectively.
- Detainees from Heathrow detention centres were sometimes brought to the ED department. The health service provider at the detention centre liaised with the department in order to provide multidisciplinary emergency care. Liaison meetings discussed advance care planning and managing needs better.
- The reception system was not well signposted and it was not straightforward to understand what process was in place to book in on arrival. There were four desk spaces at reception, marked 'urgent care nurse/urgent care centre' (across two spaces), and 'accident and emergency' across the top of another one. There was no indication of which one it was most appropriate to go to.
- There was no dedicated receptionist in children's ED and there did not appear to be any booking in process once patients had come in to children's ED area.
- There was a lack of visual information regarding the location of toilets, telephones or other departments.
- There was a television on the wall showing Hillingdon Hospital messages and mostly accident compensation adverts. Compensation adverts were also on posters on three walls. There was minimal other patient information. One small leaflet dispenser offered first aid advice and one floor-mounted noticeboard was entitled 'overseas visitor's board', which had two small notices in English.
- Information about various conditions was available in other languages on request, but staff we asked were not sure which languages were available.
- In the paediatric ED, leaflets about conditions were available, including in other languages.
- We were told there was a telephone translation service available. Some staff told us they had experienced long waits for translation services. We spoke to one parent for whom English was not their first language who had visited the department on a number of occasions and whose son had complex needs. They said, "English is not my first language, so when I come in I just wait for someone to speak to me. No one has ever offered to speak in my first language about my son."

Meeting people's individual needs

- We observed patients generally being seen promptly on arrival by reception staff. Rarely was there anyone waiting to be booked in. At one time, we observed eight people at the reception area. These were quickly assisted by staff.
- Staff managed the reception area well during busy periods and were helpful towards people waiting. However, we observed and spoke with an 87-year-old woman with visual impairment who was having difficulty negotiating the reception system. The department and main area were busy. After standing around for approximately ten minutes, she sat down without having booked in. Staff did not pick-up on her vulnerability, or that she was confused by the process
- There was no system to inform patients how long the wait was, or who they were waiting to see. We spoke with one patient who had been waiting for two hours, having been given some pain relief on arrival. They said: "it is not so much the waiting, it's the not knowing what is going on or what you are waiting for. You sit and see other people come in and get seen and you think you have been forgotten."

- The main waiting area was shared between the UCC and the hospital's ED department.
- The children's waiting area was small, and only had toys for the youngest children. There was insufficient seating in the children's ED waiting area when the department was busy.
- The waiting area for younger children was audio-visually separate from the adult area and had a gate so children could not run out. However, it was too small to take both UCC and ED child patients. This meant children had to wait in the main adult waiting area, which was often crowded.
- The treatment room in paediatric ED for nebuliser use had three high-voltage hazard warning signs, a broken clock and nothing to look at that was child friendly. Each cubicle had a faded 'Disney' picture. There were also no child-friendly pictures in the observation area, or the paediatric resuscitation bay.
- We spoke with a teenager who had to wait in the adult ED waiting area. This was standard procedure, due to overcrowding.
- We witnessed a known cancer patient being taken through to the assessment area from reception, for assessment and asked to sit on a chair. Due to lack of space and an available trolley, the patient was assessed in the treatment room, which held the plaster trolley. This room was not equipped for unwell patients, or suitable for a cancer patient. One consultant told us that they used the treatment room 80% of the time, due to lack of proper space for patients, so its use was not a one off. This patient was in this room from approximately 11:30am until at least 2:30pm.
- We spoke with a mother and daughter with a hearing impairment, who told us there was no digital hearing 'loop' system. This meant any communication had to be assisted by the mother, despite the daughter being fully able to communicate her own needs. The mother also told us that the lack of a ticket system or display screen meant that her daughter would not hear the staff calling out her name if she were alone.
- Psychiatric liaison was provided by a mental health nurse based on site, from a local mental health trust. Patient assessment took place in a private room. This was not considered to be a suitable space for patients to wait in, either for assessment, or a Mental Health Act assessment, because there was no natural lighting and no ventilation. This meant patients generally waited in the main ED waiting area, which was often crowded. Staff reported delays in assessments taking place, which raised the risks of patients leaving before they were seen and heightened the levels of distress for the patient.
- We did not see notices, or information regarding asking for a chaperone, but did observe a consultant asking the administrator to chaperone when he went to see a patient.

Access and flow

- So far this year (2014 to 2015), the trust had managed to achieve an average waiting time of 95.2% of attendances in ED to be admitted, transferred or discharged within four hours. This was against the national ED waiting time target of 95%.
- Performance data for the department showed that, although the trust had almost achieved its overall target of 95%, this had been achieved by the good performance of both the UCC and the trust's minor injuries unit at Mount Vernon Hospital. The hospital's ED department performance was 87%.
- For the second quarter of this year (July to September 2014) statistics showed the trust had performed better than the England average for the percentage of emergency admissions who had to wait between four and 12 hours in ED from the decision to admit, to admission.
- The department performed better than the England average for the percentage of patients leaving the department without being seen. This figure was around 2.5%.
- The trust performed better for patients coming back to the unit with the same condition for further treatment. There was a re-attendance rate of 7.1% against an England average of 7.6%.
- The trust reported zero breaches of patients waiting in the department over 12 hours from the decision to admit to admission.
- ED staff reported to us that there was a lack of access to beds within the hospital, which meant there were problems with patient flow out of ED. Staff attributed some delays to ED as they were not able to admit to wards without the ward consultant's agreement.
- We spoke with staff about pressures and demands that took them away from fulfilling their duties. We were told that transporting patients around the hospital and on to wards and waiting for the handover took staff away from the department.

- Staff also attributed discharge delays to the allocation of patients to a variety of wards, which meant that ward consultants were visiting up to five different wards for one ward round. Other staff told us delays in completing medical tests also caused delays to discharge.
- The ED report for the week of our visit showed reasons for delays in meeting the four-hour target (breaches) as: waiting for a bed, no hospital bed, waiting for treatment, and waiting for results.
- Emergency task force meetings were held weekly. This involved the bed management team, commissioners and social services staff that were specific to patient flow and improvement of the patient journey.
- On the first day of our visit, between 12:30am and 3:30pm, the trust had recorded two clinical breaches and three bed breaches. There was an average of 18 breaches a day, due to a lack of bed availability. At 2:55pm there were 38 patients in the department. Fourteen were showing as 'red' on the system as a breach. This was equivalent to 37.8% of patients breaching at that time.
- An establishment review was carried out following the introduction of the UCC. The trust was looking to reduce staffing numbers, as it was estimated that 60% of the workload would be taken by the UCC. However, numbers visiting ED continued to rise. We were told there was an average daily attendance of 120 to 130 patients a year ago. Now this figure was approximately 180 a day.
- A number of staff told us that it felt like the winter surge had carried on since last winter. Trust leadership told us the department was too small for the numbers of patients coming through the doors.
- One member of staff told us, "resus[itation] is constantly full. Majors activity has shot through the roof."
- Dependency, or acuity of patient needs was not measured within the department. There were plans to start using a dependency tool to measure acuity from 1 November 2014.
- There were no protocols for ED consultants to admit patients from ED.
- The length of time patients had been in the department began once they had been booked in by the UCC. If a patient became unwell or was not suitable to be treated by the UCC, they were transferred to the ED. Staff told us that delays caused breaches, as they had already been in the department for some time before they joined the ED queue for treatment.
- However, despite these delays and the clock beginning in the UCC, the trust was meeting the four hour national target to admit, transfer or discharge patients within four hours.
- Staff on reception duty told us that it was extremely busy all of the time and they did not often get a break. We observed that the ED receptionist was busy and divided their time between the front desk, booking patients in, booking ambulance patients in at the front desk and carrying out administrative tasks, such as scanning notes onto the computer system.
- Patients assessed as needing emergency care who had walked into the department were seen by a nurse and investigations such as bloods and x-rays were carried out in the three cubicles in the assessment area.
- Bloods were taken by a phlebotomist, but staff stated that there was sometimes a 30-minute wait, or longer. We noted that a patient was booked in, seen initially six minutes later, but then waited 45 minutes for further assessment. If patients needed to go to Majors after assessment they waited for a cubicle to be free.
- There were two nurses and a senior doctor on duty in the morning, three nurses and a doctor in the afternoon plus a float nurse working in the assessment area. We spoke with one nurse and one consultant who said that there was insufficient space to see patients.
- During September 2014, 26% of walk-in patients were children. All were visually screened by a nurse from the UCC within 15 minutes of arrival.
- At times, communication between the ED and UCC was not effective. We observed confusion over where a child was while waiting to be seen by a surgeon, leading to wasted time for the clinician and the patient.
- Senior managers were aware that bed pressures were leading to delays in admitting patients to the children's ward. This was causing a bottleneck, which needed to be resolved to minimise the waiting time of young patients.

Learning from complaints and concerns

- Complaints for investigation were dealt with by the matron, business services manager or nurse consultant. All investigations were completed using a set format and included an action plan when there were measures that had been identified to make improvements.
- All complaint responses were reviewed by the medical division's matron. The complaints manager then wrote the response to the complainant. There weren't many

actions identified from the responses. We could only locate two out of 10 complaint responses that had identified any learning for staff. The matron told us that this was because most complaints did not warrant this.
- All complaints were stored in a folder and reviewed in monthly clinical governance meetings, which also discussed complaints and ongoing issues.

Are urgent and emergency services well-led?

Requires improvement

The department had a vision and strategy for its future, which included increasing the capacity of the department to meet the increased activity of the service. Redevelopment was already underway.

Trust-wide for emergency admissions and including the privately managed UCC, the trust were achieving the national four hour waiting target in 2014/15 to date.

The department faced a number of risks in the present, which had not been effectively mitigated. The environment had not been well maintained, despite the trust and department leadership being aware of its condition. Infection control audits indicated that the environment was 100% compliant, despite a number of issues we found during our visit. Trust and departmental leadership were also aware of the privacy and confidentiality issues at the front desk, but little had been done to mitigate this. Overcrowding in the department had added strain to relationships between nursing and medical leaders.

Despite a 7% spike in non-elective admissions which had been sustained since Easter 2014, there was no formal policy on overcrowding and the obvious delays caused by the demands on medical consultants meaning they weren't able to assess patients in a timely manner had not been addressed.

Vision and strategy for this service

- Staff told us about the trust's CARES values: compassion, attitude, responsibility, equity and safety. Its values were used as a framework for annual appraisals and used in the recruitment of staff in ED.
- Staff had also undertaken training on embedding these values. All staff were expected to attend customer care training as part of this strategy. We were told that staff who had been identified as having weak communication skills were attending customer care training first.
- The department had a vision and strategy for its future, which included increasing the capacity of the department to meet the increased activity of the service. It was widely recognised by the trust leadership that the service needed more capacity. The chief executive told us that the size of the department presented challenges in relation to the amount of activity.
- Redevelopment was already underway in the shape of a new building, funded through 'Shaping a Healthier Future'; a strategy for developing North West London's healthcare provision. A new 46 bed acute medical unit (AMU) was being built. It will be adjoined to the current ED department and was planned to become operational by December 2014. In addition to this, we were told that the paediatric ED will be reconfigured by December 2015 and that extra cubicle capacity would be built in to the main ED department by December 2016.
- The trust's vision was to replace its emergency assessment unit (EAU) with the AMU. The current patient pathway was segregated because the EAU was on the fourth floor and under separate management from the ED department.
- The trust's intention was to develop a more seamless patient pathway by developing cohesive working between ED and the AMU.
- There was no formal policy on overcrowding in the ED.
- Consultants could not admit to the wards without ward consultant agreement and there was a lack of strategy to deal with issues of the present. All hopes seemed to be pinned on the opening of the new acute medical unit.

Governance, risk management and quality measurement

- The department faced a number of risks, which had not been effectively mitigated. The environment had not been well maintained, despite the trust and department leadership being aware of its condition. Infection control audits indicated that the environment was 100% compliant, despite a number of issues we found during our visit. Trust and departmental leadership was also aware of the privacy and confidentiality issues at the front desk, but little had been done to mitigate this.

- The department held monthly clinical governance meetings, attended by consultants, the service manager and senior nurses. Minutes demonstrated that audits, complaints and incidents were all routinely discussed.
- Clinical governance meeting minutes showed that the department's entries on the trust risk register were reviewed and updated with actions allocated to key members of staff. Morbidity and mortality was also reviewed as part of this meeting.
- The monthly clinical governance meetings fed into the monthly clinical quality board meeting for the hospital's medical division, the division to which the ED department belonged within the hospital structure. Minutes showed that ED staff were represented at this meeting by medical and nurse service leads.
- There were weekly business meetings within the department.
- We were told that team meetings also took place within the department, but had been poorly attended due to staff not being willing to come in on days when they were not on duty and that it was not possible for staff on duty to attend these. Efforts had been made to improve attendance through offering food and organising shifts to coincide with meetings.
- The reception staff told us that they did not have team meetings and were not always kept informed of any changes within the department. They also stated that they were not involved in meetings with the UCC to discuss reception issues.
- Urgent care task force meetings occurred monthly with the London Ambulance Service, the rapid response team, the mental health provider, the bed management team, the emergency assessment unit sister, the ED matron and the local authority.
- Patient dependency / acuity needs within the department were not currently measured. Staff recently attended an emergency care and trauma conference and learnt about a dependency tool to measure acuity, which will be in used from 1 November 2014. A visit to an acute trust was planned where the tool was being used on a daily basis.

Leadership of service

- The department belonged to the medicine, rehabilitation and emergency care division within the trust. There was a medical and nursing lead with overall responsibility for the department, who reported to the trust board.
- There was a lead consultant for the department and other consultants took on specific duties, such as being allocated to the floor and different areas.
- The nursing leadership structure within the department consisted of a matron, nurse consultant and business services manager. Each role held specific responsibility for different duties, such as practice development, performance and shift coordination. Shift leaders led individual areas within the department such as the major treatment and assessment areas.
- During our inspection, we observed that senior nurses and consultants had a visible presence within the department and provided supervision and ongoing support to staff.
- We were told that the chief executive and director of nursing were supportive and were well aware of the pressures staff felt they were under. The director of nursing worked in the department on occasion.
- The leadership question of whether the paediatric ED was part of the women's and children's division, or the medicine, rehabilitation and emergency care division needed resolution.
- During our visit, we learned that both the nurse consultant and lead consultant were leaving their posts, presenting a further challenge to the department.

Culture within the service

- The nursing and medical leads for the medicine, rehabilitation and ED division spoke about the premises size for the number of people coming through the door, how relationships could become strained and the need to move things forward in this respect. The main element of this was to develop a supportive culture within the department.
- There were mentoring roles for key staff and trips to specialist conferences. There was a plan to rotate nurses through ED and the acute medical unit when it came online in December 2014. Also to rotate staff between the medical wards and paediatric staff with a specialist children's hospital.
- Junior doctors told us they felt well supported by their consultants and middle-grade doctors. Junior nurses also told us they felt supported.
- Senior staff were aware that staff morale was not good and that staffing and workload issues had had an effect.

This information had been highlighted in the NHS Staff Survey 2013, where workload pressures were identified as being 'worse than expected' when compared to other trusts.

- We observed a friendly and helpful department during our visit. Ambulance staff we spoke with also told us that they felt the department was welcoming and friendly.

Public and staff engagement

- We were told that apart from the NHS Friends and Family Test there was no other public engagement.
- We did not see information in the ED about compliments and complaints.
- Parents and children had not had input into the design of the new building, but we were told the trust were considering involving them in the design of the new paediatric facilities.

Innovation, improvement and sustainability

- A new 46 bed AMU was being built that will be adjoined to the current ED department. This will be operational in December 2014.
- We were told that the paediatric ED will be reconfigured by December 2015 and that extra cubicle capacity would be built into the main ED department by December 2016.

Medical care (including older people's care)

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

Information about the service

We inspected all the medical wards at Hillingdon Hospital. These included rehabilitation, stroke, gastroenterology, elderly care, haematology, emergency assessment unit, acute assessment unit, coronary care unit, cardiology, respiratory, endocrinology, and winter pressure/surge wards. We spoke with 67 members of staff including doctors, nurses, Allied Healthcare professionals, and support staff at a variety of levels, from divisional leadership to ward clerks and unqualified nurses. We also spoke with 25 patients, family and their friends. We checked 39 patient records and 23 pieces of equipment over three days and one evening.

The trust had 59,016 inpatient admissions in 2013/14, and a population catchment of 300,000 people. Just over half of the admissions were emergencies, with the rest being day or elective cases, mostly general medicine, gastroenterology, clinical haematology and pain management. The trust had 416 beds.

Summary of findings

Although we received mostly good feedback from patients, we had a number of concerns with the medical wards at the hospital. Many areas of patient safety did not mitigate evidence risks, such as staffing levels, equipment cleanliness, monitoring checks and the number of patients coming to harm.

Patient outcome performance was variable, with some areas reporting good results, but others were either poor or not reported at all at a local level. This inconsistency was also reflected in the following of national and local guidance across specialities.

Bed management was a major concern, with high bed occupancy and outliers (patients being cared for outside of the ward in which their condition is supposed to be managed) across the hospital. This meant that the medical leadership were reacting on a day to day basis to the service need, and plans to date had brought little improvement.

Medical care (including older people's care)

Are medical care services safe?

Inadequate

Staffing levels did not meet national guidance, or the trust's own dependency and acuity tool calculations on a number of wards, despite agency staff meeting some of the unmet demand. Equipment checks were variable across the medical wards and there was a high patient harm rate such as pressure ulcers, and falls. Many items and areas were not clean and the environment was in need of repair in the majority of areas visited.

Records were not always secure and were occasionally incomplete. Medicines were not kept appropriately in a number of areas and there were often delays, or missing medicines on discharge.

Incidents

- Several Incidents were reported in April 2014 that equipment was not always being maintained, or was not available when staff required it. Learning had evidently not been implemented as we observed that equipment was not always being maintained.
- There had been ten serious incidents reported within medicine in 2013/14. These included four high grade pressure ulcers, two incidents of suboptimal care and a patient suicide.
- An average of around 250 incidents were reported per month which mostly consisted of falls (both with and without harm), low grade pressure ulcers and low levels of staffing. The last ten incidents reported within medicine included five falls and two staffing level concerns.
- A number of recommendations from incidents in 2013 were about reinforcing existing protocols, which were seen as weak after review and root cause analysis. One action from these incidents was to bring in safety crosses to identify patients at risk of falls with the intention of raising awareness and reducing falls. However, this had not been consistently implemented across the medical wards.
- Mortality and morbidity meetings took place as part of the clinical governance forum and minutes from these suggested learning took place from each death including changes to clinical practice. However, the minutes of these meetings showed only senior members of staff attended these and junior members of staff told us the discussions at these meetings were not shared with them.
- Many staff struggled to identify a recent incident from which learning had been implemented, but they were all able to report the process for logging and submitting an incident. Staff told us that there was little time to discuss incidents or to debrief after an incident.

Safety thermometer

- There was a high amount of falls within medicine. Many wards had falls with harm, medicine errors and pressure ulcers in the latest safety thermometer results we reviewed - with high amounts of pressure ulcers also on most wards. The trust projected a reduction in the number of falls in 2013/14, however, there was a high amount of falls and pressure ulcers recorded within medicine. Many wards had falls with harm, medicine errors and pressure ulcers in the latest safety thermometer results we reviewed.
- There was no skin integrity assessment tool in use on one of the winter pressure wards and none of the staff were able to tell us what the department was doing to reduce the amount of pressure ulcers, despite the quality committee implementing additional education for staff.
- Some wards reviewed their performance at handover and safety crosses had been put in place in some wards to highlight pressure ulcers and falls.
- Venous thromboembolism (VTE) compliance audits showed positive completion rates. The trust was only auditing whether the patient had a VTE assessment with a target of 95% of assessments for VTE being completed. There was no assessment of whether or not any intervention was required and if it had been carried out.
- For the assessments carried out in May, June and July of 2014 the trust was not meeting the 95% target with percentage scores of 89, 88 and 93 respectively.
- Urinary catheter assessments audits also showed a positive completion rate of over 95% in most wards.

Safety thermometer results were not displayed on some of the wards we visited which meant that patients and visitors were not made aware of the results.

Medical care (including older people's care)

Cleanliness, infection control and hygiene

- Some parts of infection control audits were not always taking place, and where they were taking place we noted poor findings. Audits not taking place included hand hygiene, bare below the elbow, visual infusion phlebitis scores and environment cleanliness.
- There were low infection / cleanliness audit scores where they were audited, such as medical devices on Grange ward (71%), Infection Prevention and Control training (most wards were lower than 80%), linen rooms closed (50%), pillows stored correctly (67%), aprons worn when stripping beds (71%), correct isolation signs (64%) and isolation doors closed recorded at 28%. No actions were reported against these audits to improve scores.
- We observed that commodes in the cardiac care unit had not been properly cleaned.
- Most staff we observed were compliant with infection control procedures, such as washing hands between caring for patients, when entering and exiting wards and in wearing personal protective equipment, such as aprons and gloves when necessary. However, there were some wards where staff did not wear aprons as required.

Environment and equipment

- Maintenance and cleaning checks for equipment was variable across the wards with some equipment having no stickers on them to show they had been cleaned, or old stickers, including one sticker that dated back to 2002.
- Some resuscitation equipment was not checked daily.
- None of the equipment we checked had up to date portable appliance testing (PAT) stickers on them. We saw a BP monitor that had last been checked in 2011.
- There were some wards without a central list of equipment checks.
- We noted checks on the equipment in the gym were variable and it was unclear from records when equipment had last been tested.
- We were told that a bath was not being used due to safety reasons, but staff did not know what these reasons were and if the issue was being addressed.
- There was only one metre distance between each bed in the tower block medical wards; this meant that there was only 50cm distance between the bed and the dividing curtain. As there were storage lockers between each bed and the wall, this meant there was a lack of space to fit equipment, such as a resuscitation trolley or a commode.
- Some areas of the environment were dirty, such as some windowpanes that had visible smears of dirt on them. Windows and floors, in particular, were poorly maintained; with duct tape holding in or sealing many damaged areas.
- A toilet was not clean and had a broken mirror. Heavy dust was found behind a sink and on a window ledge. This was pointed out to the facilities management team and, upon re-inspection the following day, was found to be clean.
- Many doors storing either hazardous waste or equipment were left unlocked and sometimes were also left open.
- It was noted on the trust risk register that patients had absconded. Despite this we noted doors open leading from wards to garden areas with patients with confusion staying on the wards.
- Corridors were being used to store equipment, such as resuscitation trolleys, and chairs. This meant that the corridors were cluttered and posed a risk if a patient had to be transported in their bed, although we did not observe any patients being delayed in being transferred due to this
- Some staff reported there were not enough stethoscopes or oxygen saturation monitors which meant there was a risk staff would not be able to monitor or treat patients with all the equipment they needed.
- Trust management told us that additional pressure relieving mattresses could be hired from an external company if there were internal delays in providing these for patients. However, despite this provision, some staff on wards said accessing pressure relieving equipment, such as mattresses, was sometimes delayed by several days.

Medicines

- Incidents were reported in March 2014 that controlled medicines were not being stored appropriately on general medical wards. When we checked, it was evident that action had been taken as controlled drugs were stored correctly on these wards.
- Some medicines were in fridges where the temperature was either inappropriate, or was not checked correctly.

- An audit of medicines not given when required, medicines being available and rewriting of prescriptions showed poor results with many wards either not reporting or being found to be non-compliant on 20% to 60% of occasions.
- Staff reported Tablets to Take Away (TTA) were often delayed and that sometimes medicines went missing although no incidents had been reported in September regarding this. Some patients were discharged without TTA and, therefore, either had to come back or never received their medicines. Others were given envelopes containing a few tablets until they could pick up their TTA. This meant that nurses were dispensing medicine which does not comply with medicines management guidance.
- We received a concern from a patient on the emergency admission unit that they did not receive their normal medicines at the weekend, and they told us this was due to the pharmacist not being available. Around ten of the 39 drug charts that we checked in patient records were incomplete.

Records

- Although some of the 39 records we reviewed were complete and had appropriate information, such as risk assessments for skin integrity and falls, many of the records we reviewed did not have signatures to show who had completed the review of the patient. We found a few sets of records which had another patient's notes within the file. Some medical notes were not legible.
- On a number of wards, records were either not secure or were temporary. Many wards left patient records in a cubbyhole or trolley that could be accessed by the public either in the middle of the ward or at the nurses' station. Other sets of records were loose-leaf and had been filed in envelopes, some dated as far back as February 2014 that hadn't been incorporated into the main patient record.
- Staff estimated that only 75% of notes were available on the ward and there were frequently delays in retrieving them. Incidents were being reported but despite this, this issue was not on their local risk register.
- There were only three computers available for therapy staff in their base office and none on the wards and so often allied healthcare professionals could not access computers on wards when they needed to. Their reports would be handwritten, or had to be completed on the computers in the trust library. This meant that records might not be written straight after treatment and that there was a risk that records were not contemporaneous and were not being accurately recorded.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Most staff we spoke with told us about their responsibilities under the Mental Capacity Act 2005, although the training rates for this were poor across most wards with two wards lower than 50% of staff trained.
- A number of incidents had been reported of patients absconding. In response to these incidents the trust had introduced keypads on all of its medical wards. We found that there was no consideration of how this impacted on patients' liberty, there were no signs to inform patients on how they could obtain the access code for the keypads and there was no authorisation under deprivation of liberty safeguards for patients who were deemed to lack capacity.
- There had been an incident reported in the six months prior to our inspection where a patient had been strapped into a wheelchair without consent being taken, despite the patient having capacity. This had been discussed with the staff involved and staff now ensured consent was taken as necessary. Staff we spoke with that had been involved in the incident were now aware that capacity should be assessed and a best interest assessment should be carried out if it was felt that the patient lacked capacity. We saw recognition of correct processes and that these were being followed in relevant patient records.

Safeguarding

- Safeguarding training rates were low, with safeguarding children level 1 at 56% and level 2 at 48%.
- Safeguarding vulnerable adults rates for medicine were at 61% against a target of 90%.
- The trust wide safeguarding policy was up to date, included referring to up to date local guidance, and details of who was responsible for safeguarding within the trust.
- Most staff were aware of who to contact if they had a concern regarding safeguarding vulnerable adults at any time.

Medical care (including older people's care)

Mandatory training

- Mandatory training rates were low across medicine, with fire awareness training delivered for 63% of staff, blood taking for 78.6%, basic life support level for 54%, corporate induction for 72%, equality and diversity for 45%, moving and handling level 1 for 31%, information governance for 70% and health and safety training provided for 60% of staff.
- Particularly poor wards for making sure staff were appropriately trained were haematology and gastroenterology with 54% of staff receiving the appropriate mandatory training, winter pressure wards (55%), cardiology (48%), the emergency assessment unit (71%), respiratory and endocrinology (64%) and the stroke unit at 63% of staff trained.
- An action plan was in place to address the areas of training non-compliance.

Assessing and responding to patient risk

- Three incidents were reported that national early warning scores (NEWS) were not being highlighted or actioned.
- When we checked patient records, most NEWS were being responded to, but it was not always clearly recorded if and when an intervention had occurred.
- There was also not always a regular intervention at an appropriate time after a high NEWS result observation. When we spoke with staff about the purpose of NEWS and the protocol for escalation, some were unaware of what the protocol was. Staff were aware of the NEWS tool but not its purpose.
- Up to seven patients that required telemetry observation were in some wards other than the CCUl, but their telemetry was observed only from the cardiac care unit (CCU).This meant staff had to either call up from the CCU if there was a concern, or go to the ward where the patient was. It also meant they could not see if there was an easily visible sign as to why there was a telemetry warning, such as the patient pulling the cords off. Staff on the CCU reported this as a concern as sometimes staff on the other wards did not answer the phone.
- There was no protocol in place for patients in the emergency assessment unit on contact with the CCU, who monitored the patients.

Nursing staffing

- The trust executive team told us there was due to be an additional £151,000 investment in staffing within medicine beyond who had already been recruited, although there was no current plan to recruit staff from outside Great Britain and Ireland.
- A recent recruitment drive had meant an additional 28 registered nurses and 29 untrained nurses in June 2014, with another 13 registered and 19 untrained nurses in July 2014.
- At least five incidents had been reported in 2014/15 so far regarding low staffing levels.
- Patients fed back that they felt there was a lack of staff.
- Most wards we visited during the day and the night had less staff than their establishment, despite full bed occupancy and staff reporting patient acuity was high. The establishment was not sufficient for the patient dependency and acuity at that time.
- Overall, the trust reported day fill rates were nearly 20% below establishment for nurses during the day, although some wards reported being at above 95% of establishment. We found one ward with one qualified nurse covering 20 patients when we arrived on the ward, before two nurses joined them at different times after being requested from other wards within two hours.
- We also found one ward being covered by two bank nurses for a whole shift and no permanent staff. There were only two nurses for 20 patients at night on one ward, which had a mix of surgical, elderly and medical patients with no additional cover.
- Out of hours, senior staff reported they sometimes would move critical care staff out of the Intensive Therapy Unit if there was a lack of permanent staff on the wards.
- The trust was constantly moving staff between wards aiming to ensure they always had a permanent member of staff on each ward, but this meant most wards were below their establishment, or at least that they had a number of agency staff on those wards. Some ward staff had been covering for more than one ward on most shifts for over a year, as the trust had not recruited the extra staff they needed.
- One ward had at least 27 and up to 29 of its patients at level 1b in the last week (stable but acutely unwell patients), but had four nurses covering during the day and only two at night when the acuity and dependency

would recommend at least an additional nurse. Staff told us the lack of staffing was particularly apparent when they had a very unwell patient, due to the amount of input they required for appropriate care and support.

- On NHS Choices, the trust reported meeting safe staffing levels in June 2014 at 93% of the planned level and used an approved tool to work out staffing levels, depending on patient acuity and dependency. This did not reflect what we found at the time of our inspection.
- There were high variations in whether the trust met the nursing establishment on wards, with figures varying from 76.5% to over 100%, depending on the ward and shift. Vacancy rates were also variable, with many wards having over 20% vacancies and an overall rate in medicine of 7.75%, which equated to nearly 30 vacancies including the temporary wards.
- This was worse than in April 2014 and there had been three incidents raised on medical wards that staffing levels were not safe. The trust reviewed its staffing levels in June 2014 and recognised that the cardiac care unit was not funded for the amount of staff they required and the incorrect level was being applied to the rehabilitation, cardiology wards and emergency assessment unit. Staff establishments were worked out on the basis that up to 23.6% of staff were on annual leave or sick. Overall, senior staff felt there were 37 qualified nursing vacancies and 13 unqualified nursing vacancies across the medical wards which were being recruited to.
- There was a suggested pilot of having band 6 supernumerary nurses five days a week, but due to workloads, it was not possible to implement this pilot.
- Agency / bank use was high, with up to 32% in the winter pressure wards according to the trust staffing figures for July 2014.
- We were concerned by the quality of temporary nursing staff induction on to onto wards, as, although there was a comprehensive checklist for agency staff to complete that covered trust wide protocols such as health and safety, ward induction and infection control, these were not always completed.
- Although nursing staff went through a handover sheet, which detailed each patient on the ward with their current status, the expected discharge date and what treatment they were undergoing - none of the wards we observed introduced the new staff on shift to their patients at each patient's bedside.
- In addition, we saw two handovers carried-out by one agency nurse to another agency nurse with no permanent nursing staff at the handover. The agency staff nurse handed over to the permanent member of staff once they arrived from another ward. The matrons rarely attended any handovers which meant that they did not observe these issues and the quality of the handover was not assessed.

Medical staffing

- There was a high number of junior medical staff who were locums and many of these had only had contracts for three to four weeks.
- At night, there was an on-call consultant, a registrar and two junior doctors. One junior doctor covered patients being admitted to the hospital, the other one covered the wards.
- This team had to cover all the medical wards, including those patients that had been in the emergency assessment unit longer than 24 hours. Staff in many wards felt the amount of medical cover at night was a concern, with reports of medical reviews taking several hours to be arranged which had been reported as incidents but was not on the risk register.
- We observed an effective medical handover process at the end of the day shift, with important patient information being shared between staff, including discharge coordinators, with patients allocated based on need. However, there was no physiotherapy input.
- There was no dedicated anaesthetic support for the cardiac care unit, although they did review patients that were level 2, when requested.
- Medical specialities operated in 'safari rounds' meaning doctors were not allocated to specific wards. This meant when a consultant ward round took place, that the team had to visit other wards. However, when we reviewed patient notes, all the patients had been seen by a consultant every 24 hours.
- The one take team on duty took responsibility of patients admitted during their shift. These patients, although normally handed over to a doctor specialising in their condition the next day, we found they were often being allocated to wherever there is an empty bed in the hospital rather than a ward specific to their condition. This meant a number of medical ward rounds took place on each ward, each day. Nurses expressed concern that in a number of areas this meant

sometimes patients missed having their 24-hour review by a doctor due to the spread of patients. However, all the records we reviewed showed that patients were receiving 24-hour reviews.

Are medical care services effective?

Requires improvement

The trust participated in national audits with varying results across specialities.

The department could not be assured that all staff were competent in caring for the patients they treated.

Evidence-based care and national guidance was not universally applied, and staff were sometimes unaware of the guidance to follow. Multidisciplinary team working was in place, but staffing levels affected the level this was achieved at.

Evidence-based care and treatment

- Staff were not always aware of national policies and protocols, but knew trust-wide guidelines. This was despite discussions on current clinical guidance at clinical working group meetings.
- A monthly clinical effectiveness check was completed on each ward, which covered completion and clarity of records, focusing on pressure-ulcer prevention, falls prevention and the recording of medicines administration.
- We observed care being undertaken in line with their care plan and risk assessments such as nutritional, falls and skin assessments.
- An audit of upper gastrointestinal bleeds took place in June 2014, which showed poor documentation of the Glasgow-Blatchford Bleeding Score, but the majority of patients were referred for an endoscopy - although this was a small sample. Actions were put in place to improve compliance.
- The trust had variable results for the continence audit. Results were above average for cause of bowel condition and for condition-specific interventions in both age groups. Results were also above average for treatment plans in both age groups. Results were below average for long-term management of incontinence in both age groups. This gave the trust an upper-quartile median score for over 65 year olds, but a middle-half score for under 65 year olds.

Pain relief

- Most patients we spoke with reported receiving pain relief when they required it and this was recorded appropriately including the use of a pain scoring tool.

Nutrition and hydration

- Patients we spoke with told us they receiving nutritional support when they required it such as help to eat, supplements or pureed food.
- Most patients reported being happy with the food and they received a choice of meals.
- On wards we observed protected meal times took place including doctors not reviewing patients during this period, and the times for this were clearly displayed.
- We observed water was always within reach of patients.

Patient outcomes

- The renal colic audit for 2012/13 showed that the trust fell either in the middle 50% or lowest 25% of NHS trusts, with similar or worse results than the previous audit, although there was one marked improvement.
- In the sepsis audit 2011/12 and vital signs audit 2010/11, the trust was mainly in the lowest 25% of NHS trusts.
- The trust was not a heart attack centre so did not deal with the acutely unwell cardiology patients in the first instance. Their results in the relevant audit were variable as they scored 100% on the Myocardial Ischaemia National Audit Project (MINAP) audit for patients receiving secondary medicines. However, they were worse than average for non-ST segment elevation myocardial infarctions (NSTEMIs) being seen by a cardiologist, referrals for an angiograph and angiograph post-discharge.
- The trust was not a first receiver of stroke patients, so most patients they treated were seen at least 72 hours after their initial stroke. The Sentinel Stroke National Audit Programme (SSNAP) audit showed they received the best possible rating in ten measures, including thrombolysis, and an average in 13 measures. However, they received a poor rating overall, due to poor Multi-disciplinary team working and discharge processes.
- The National Diabetes Inpatient Audit 2013 showed low compliance overall. However, an improvement was

made by April 2014, with more average scores being achieved. Areas still of concern were dietician hours, pharmacist hours, diabetes-related admissions, renal therapy, 24-hour foot assessment, medicine errors and prescription errors.

- The National Heart Failure Audit's eight measures showed the trust to be above average in two questions, but below average in six measures. Senior leads felt this had been incorrectly calibrated and they had reported their findings back to the auditor.
- Some wards were not recording some of their key performance indicators, specifically the three winter pressure (now long standing surge wards) and the respiratory and endocrinology wards.
- However, most key performance indicators were compliant on wards that completed them, such as cardiology, haematology / gastroenterology and the emergency assessment unit.
- The National Audit of Dementia undertaken in February 2013 showed there was either a lack of information or below average scores in 17 out of 31 areas, such as a lack of a care pathway and below average notice of discharge to carers, but above average or appropriate arrangements in 14 areas such as multi-disciplinary team meetings and the reason for the recording of use of antipsychotics medication.
- Emergency readmission rates were above average, particularly in elderly care, respiratory and general medicine.
- Local audits took place on some of the wards such as infection control and waste, but other wards either did not take part in these audits or they did not report their findings.
- The neurology rehabilitation ward had a series of outcome measures they used to check patient outcomes. This included The Functional Independence Measure and Functional Assessment Measure known as Fim+Fam.
- Patient outcomes on the rehabilitation ward showed patients made marked improvement on the ward, with some patients going from very poor function scores to very high ones. Overall score improvements varied, but the last benchmarking and audit summary data we received during the inspection was from 2012, which showed high improvements over most outcome measures compared to other units.

Competent staff

- There was a programme called the Leadership 100 Programme for the development of band 6 and 7 nurses. Junior staff told us they received ongoing training and teaching, with study days available to ensure staff were trained in their speciality. Other external courses and degrees had also been available to staff.
- There were high appraisal rates for staff in the medicine division, with the percentage lowest for nurses at 79% and highest for technical staff at 89%, but all were below the 90% trust target.
- Nurses reported appraisals that varied in quality and that it was sometimes difficult to find time to see their mentors.
- Delivery was inconsistent though as some staff reported receiving appraisals and revalidation with supervision every two weeks.
- On the ward which had recently been refurbished to provide an excellent environment for patients with dementia, staff were unable to demonstrate the they had undertaken appropriate training to support them in meeting this particular client groups' needs.
- On other wards, some staff told us that there was no training for them in relation to caring for the older person and others said they were caring for older people, but had not yet attended any relevant training.
- Staff were more positive about other training needs and their personal development.
- Staff on the cardiac care unit were trained to meet the variety of patient needs they treated. Although the ward was supposed to only treat cardiac patients at level 2 (high dependency), they treated level 1 (acute but not critical care) cardiology, respiratory and other conditions and staff were trained to deal with all these areas.
- However, they had not been trained in inotropes (which are used for critical care / high dependency patients) and staff told us they sometimes received patients on inotropes, although we did not observe any on the ward.
- Agency staff and locums received a ward induction and orientation, which included an information pack. However, some agency staff we spoke with felt this induction was unsatisfactory to meet their needs.

Medical care (including older people's care)

- We noted that checklists for their induction were not always completed. Agency staff were also not competent to administer intravenous therapy and insert a cannula.
- Agency staff were rarely specialised for the particular ward they covered or worked on.
- A competency workbook was in place for healthcare assistants (HCAs), which ensured they were trained in inserting nasogastric tubes, undertaking echocardiograms in full, inserting cannulas and also how to identify a deteriorating patient using the early warning system.

Multidisciplinary working

- There was use of the Royal College of Physicians tool for multidisciplinary team (MDT) working on the stroke unit. MDT working took place on the dementia friendly ward (which included staff from Age UK), and on other wards across the trust.
- The Speech and Language Therapists were involved in patient care when required, but we were told their services were at a premium as there were not enough of them to meet patient need.
- Staff reported getting support from therapy staff when it was needed. There were 30 qualified therapy staff and 30 assistants across (17 of these staff groups were physiotherapists) the trust and they conducted daily rounds.
- Some patients felt their therapy was rushed and that they did not receive enough of it. On the rehabilitation ward, one patient told us they only received 30 minutes of therapy, once a week. Senior therapy staff agreed there was particularly unmet need on surge wards and that they had to rely on locums coming in.
- Staff told us there was currently no therapy available at weekends on the medical wards. However, trust leadership told us that therapy was provided at weekends for identified patients who needed weekend input.

Seven-day services

- There were concerns reported by staff regarding radiology cover out of hours as the trust only had one interventional radiologist at the time.
- Therapies were considering working seven-days a week, and were due to consult on a business case to why there needed to be an increase in weekend numbers.
- They had also tried to extended the hours of their service, but didn't have enough staff to deliver the extended hours.

Are medical care services caring?

Good

Most of the patients we spoke with and the feedback we received was positive and our observations confirmed that staff were mostly caring and friendly towards them.

Patients, family and friends were involved in patient care and information was explained in ways they could understand.

Emotional support was available to patients that needed it.

Inpatient wards Friend and Family Test scores were variable but inpatient survey scores were better than average.

Compassionate care

- The trust participates in the NHS Friends and Family Test and had a response rate of 40% with an overall score of 63 against the national average of 72. Results for each ward were variable with five wards above the England average but six wards below the average.
- The 2014 Cancer Patient Experience Survey shows that the trust was in the bottom 20% for 22 of the 68 questions asked and in the top 20% for 11 questions. The questions where the trust scored worse compared to the 2013 survey related to information provided to patients and communication between nursing and medical staff with patients and family members.
- The Adult Inpatient Survey (2013) results varied, but most wards scored over 80% every month. Treating patients with respect and dignity scored 87% which is better than average.
- Complaints had been received regarding the rehabilitation ward and staff acknowledged that this was due to not managing patient expectations of what could be provided.
- Curtains for patients receiving care were not always pulled closed and doors were not always shut during procedures, such as the pacing room (where patients get a pulse stimulation) in the cardiac care unit. However, patients reported that their privacy and dignity was respected.

Medical care (including older people's care)

- We observed interactions between staff and patients that were mostly friendly and helpful.

Patient understanding and involvement

- Patients and relatives reported feeling involved in their care and receiving information and updates they could understand. They also said that this feedback was regular. Involvement in care on the inpatient survey in 2013/14 scored 70% which is better than average. One family told us that they had requested no male nurses for their relative and that this request had been met.

Emotional support

- There were a variety of spiritual services available for patients and their families.
- The 2013 inpatient survey showed the trust scored 56% for talking about worries and fears and 67% for emotional support being provided which were worse than average scores.

Are medical care services responsive?

Requires improvement

The trust had significant challenges in how it managed within its current bed base. The trust had 242 medical beds (including their temporary wards) plus a day case unit they could use for escalation when bed space was critical. However, this did not appear to be enough capacity and the trust had three additional medium to long term surge wards open at the time of our inspection. Patients were being cared for in these contingency wards which were created to support pressure at winter time, but were unable to close.

Issues were further highlighted by the high bed occupancy rates and a high number of patients in wards that were inappropriate for their care needs.

The average length of stay was variable depending on the type of condition the patient had, and discharge dates were rarely met, with particular concerns in discharging to ongoing care.

We noted that the trust had not upheld or partially upheld most of the complaints made about medical and older people's care. Out of the complaints we reviewed that were classed by the trust as 'unfounded' or 'rejected' all of them had elements which highlighted issues with the trust's performance, and possible errors in systems or practice.

Service planning and delivery to meet the needs of local people

- The trust had an escalation plan for opening additional beds and 60 additional beds above the planned number of medical beds were open at the time we inspected.
- The emergency assessment unit (EAU) admitted around the same amount of patients as the rest of the wards combined in the hospital, with around 1,800 to 2,000 admissions a month. This meant half of all patients were initially admitted to one ward and were due to be either discharged in 48 hours or moved to another ward. The EAU staff told us they received 10 to 12 GP referrals a day as well as admissions from A&E, which meant the ward had a high turnover of patients.
- Formalised pathways were in place for neurological rehabilitation, trauma, and spinal injuries across medicine, as patients were often seen in the nearest heart attack or trauma centre before being transferred to the trust for rehabilitation or less acute treatment. This meant the trust was seeing patients at the end of their acute pathway so they were more likely to be stable
- The trust had admitted around 12% more patients than they predicted for this time of year so capacity was already stretched beyond what the trust had planned to provide.
- No porters were available at night, so nursing and medical staff had to transfer patients themselves.

Access and flow

- There were 660 delayed transfers of care last year April 2013 to April 2014, which were mainly due to delayed packages of care in the community - patients awaiting care placements and awaiting further care.
- The local commissioning group and a patient focus group reported concerns regarding discharge planning at the hospital. However, overall delays in transfers from the hospital were 0.1% in 2013/14 which is better than the national average.
- The overall bed occupancy for the trust was 90%, with particularly high rates on the respiratory and

endocrinology ward, the acute assessment unit, stroke unit, haematology and gastroenterology ward, dementia-friendly ward and the elderly card ward - all with occupancy of above 95%.

- The spike in admissions was not accounted for in the trust's bed modelling and that had led to their winter beds being open longer than they expected.
- The trust was better than average for elective emergency readmissions by 3%, but worse than average for emergency admissions by 17%.
- Admitted 18 week pathways (national referral to treatment time targets) were better than the national average at 96.9%, with 100% rates in cardiology, general medicine, and elderly care. The trust was 10th best nationally.
- Although figures in June 2014 reported only 2.5% of all patients were outliers, there was a high amount of outlier patients (patients being cared for outside of the ward in which their condition is supposed to be managed) on older people wards.
- We observed that patients with multiple conditions were being carried for across a number of wards there did not appear to be any systematic way of allocating patients to beds so that they were being cared for with other patients with similar conditions. Around half of the patients on the haematology and gastroenterology ward did not need treatment for either of those conditions. The majority of patients on the stroke and cardiac care units did not require cardiology or stroke care, but were there for general medical care.
- The dementia-friendly ward had patients on the ward who were not diagnosed with dementia and yet, there were general medical patients with dementia on other medical wards.
- Side rooms were also being used for patients that had no additional needs such as end of life care, additional observations or infections. When we observed the bed management meeting there was little discussion of the medical needs of the patient, just a discussion around ensuring that patients had a bed.
- Patients were allocated regardless of the specialist training or experience of the nurses on the ward, or even the environment.
- There was no bed management meeting at night, but staff were on call, if bed management required further discussion at night. Bed managers did visit the wards daily to get the bed status.
- The average length of stay, and readmissions were worse than average with particularly high bed days in rehabilitation. However, the elderly care length of stay was reducing. Overall length of stay for medical wards that were not rehabilitation wards was 5.8 days this year, a reduction on previous years.
- We reviewed data from 2013/14 which told us that most patients did not move once they were admitted to the hospital with 22% of patients moved once and 1% moved four or more times. However we were not informed how many of these were non-clinical and this was not being reviewed by the trust.
- There were a high amount of out of hours transfers of patients and staff told us they always saw at least one patient transferred after 11pm.
- While on inspection we were made aware of four patients being moved from one ward in one night, all after midnight and for non-clinical reasons.
- A number of incidents were logged, complaints received and also reported to the Commission regarding issues with discharge.
- Estimated discharge dates (EDD) were in place but these were changed regularly throughout the patient stay with dates being recorded and changed the day after admission, halfway through inpatient treatment and sometimes two days before discharge. Despite this, these dates were rarely met and we saw a number of patients where their EDD had already passed. Staff told us these delays were usually due to delays with packages of care.
- There was a 'Home Safe' team, which included physiotherapists and occupational therapists to support discharges, so patients could go home within two days of being referred to the team. Most staff praised the work of the discharge team and felt there was close liaison. The local teams were not aware of any evaluation or information about the team's effectiveness, but after our inspection the trust leadership informed us that outcomes were audited and that there had been a 20% increase in the number of patients over 65 who had been discharged home directly from EAU.There was no discharge lounge, as this had been used to accommodate more inpatient beds. This meant day rooms on each ward were being used for patients due to be discharged which increased the number of patients that the nurses were responsible for.

Medical care (including older people's care)

- On the last day of our inspection, every medical ward was open, including all the winter pressure wards and the day case unit. This meant the trust had no additional capacity for any increase in admissions.

Meeting people's individual needs

- The 'This is Me booklet', a document designed so that staff caring for patients with dementia know how to meet their individual needs was not always completed for patients living with dementia on the medical wards.
- The trust had a 'loop' system, but had not audited its provision for blind and deaf people since 2008.
- There was no dedicated lead for patients with learning disabilities and none of the staff we spoke with were able to identify that there was a link with local authority nurses to support these patients which we identified for other services. A nurse specialising in caring for patients with dementia had been recently appointed.
- The trust had no leaflets about dementia available for patients, relatives or carers. There was information available electronically but not on the wards.
- Although there were advertised visiting times, patients, their family and friends told us these times were flexible depending on their circumstances, such as having to travel from a distance.
- None of the leaflets we reviewed were available in languages other than English despite the population the trust served. The only leaflet we found that 'referred' to other languages was a leaflet on maintaining privacy and dignity.
- Most leaflets were condition specific for the ward, however, patients were often not on the ward that specialised in their condition.
- There were visitor cards and ward information leaflets for each ward that described visiting times, who the matron in charge was, contact numbers and general information on dignity and what to do if visitors became unwell - although some of these were out of date, such as one on the cardiology ward which should have been reviewed in 2010.
- There was no activity coordinator for any of the medical wards
- Assessments of patients' frailty were undertaken on only some of the wards, despite older patients being on most, if not all of the wards we visited.

Learning from complaints and concerns

- When we reviewed five complaint responses about the medicine directorate, they all explained the complaint as the trust understood it and gave an answer to all the queries in the complaint. This was done in a way that a layperson could understand.
- We noted that the trust had not upheld or partially upheld most of the complaints. For the complaints we reviewed that were classed by the trust as 'unfounded' or 'rejected' all of them had elements which highlighted issues with the trust's performance, and possible errors in systems or practice.
- Also we did not see action plans in place with specific actions to address the issues raised by the complainants, other than reminders for staff to attend customer care training.
- We observed complaints information posters while on inspection and the patients we spoke with told us that they were aware of how to complain.
- Several of the staff we spoke with did not know the trust process or the local process for managing a complaint and only some staff could give examples in which they and the ward had learned from a complaint.
- There had been three complaints regarding the rehabilitation ward in the last month regarding patient expectations, attitude of staff and quality of care. Action had been taken to improve staff communication with patients, improving training availability and infrastructure on the ward.
- Compliments regarding therapy staff were shared with the staff who had been complimented.
- One matron was in charge of complaint responses for the whole of the medicine division.
- Complaints leaflets contained information on how to complain and the process to follow, but the leaflet was only available in English.
- There had been 21 complaints since July 2014 with the majority of issues relating to communication, attitude of staff and unsatisfactory discharge.
- Of the 21 complaints, 18 were responded to within either 28 days or the timescale agreed with the complainant.
- There had been 18 complaints about the emergency assessment unit, mainly about the attitude of staff and communication around discharge in the last month.

Are medical care services well-led?

Medical care (including older people's care)

Requires improvement

There was a lack of awareness on some wards of the trusts vison and strategy for medicine, with many staff only having the capacity to address day to day tasks.

There was an awareness of the challenges, however, the actions in place to address known issues were not working and alternative actions or plans were not shared with the inspection team. The delivery of care and treatment in medicine was reactive, and the division was fire-fighting problems, not identifying and making sustainable changes.

Although there was a positive attitude to team-working, due to the pressures staff were under there was low morale in a number of areas. This had contributed to high turnover in some wards.

The division did not demonstrate organisational learning or true engagement with patients, or genuine responsiveness to either individual needs or responsiveness to complaints, despite there being themes.

There was not sufficient monitoring of the patient experience.

Vision and strategy for this service

- The trust was building a new acute medical unit (AMU) that would provide a further 46 beds in December 2014, which would be governed by the emergency department.
- Senior staff were aware of the concerns regarding capacity and outliers across the medical wards and stated that they had some plans in place to reduce these issues. However, although the trust leadership were able to inform us of current and future plans to reduce admissions and improve discharge, these had not proved very effective considering admissions were still increasing and discharges were being delayed.
- Senior staff also acknowledged that the winter period was unlikely to see a noticeable change in the way the service was being delivered and the challenges it faced, despite the new AMU - due to the additional admissions they were likely to receive.
- They recognised the staffing level concerns but felt that the ongoing recruitment of staff would alleviate this problem.
- Ward based staff were unable to tell us what the vision of the trust and their area was, although some were aware of CARES, the trust's values. Some staff told us they were only working day to day, with no vision for the future.
- Therapies leadership acknowledged that they needed to step back and have extra time to have a structured vision. They had developed a business case to increase therapies to seven-day working to cover weekends, and extending their hours of availability in the working week. This was not part of a specific vison or strategy at the time of our inspection.
- After a consultation, the medicine division had agreed to a restructure of nursing, including reducing the amount of layers of management and appointing a nurse consultant for acute medicine - as well as additional management posts at clinical lead and clinical director level to improve the supervision and oversight of the acute medical pathways.
- A proposal was mooted that the service planned to move to a junior doctor model where they are allocated to wards rather than doctors seeing patients in different wards, but this was no more than a discussion at the time of our inspection.
- There had been a plan to either close wards or change the EAU to only admit surgical patients, but senior staff expected this not to be possible, due to the expected demands of the winter pressure for medical beds. There was also an expectation that they may have to use some beds on their other site at Mount Vernon to cope with the amount of admissions over the winter.

Governance, risk management and quality measurement

- The medical division had a dashboard to monitor performance, although this was not clearly monitored at their divisional meeting.
- The dashboard included the average length of stay, bed occupancy, readmissions rates, safety thermometer, infection control, staff sickness, turnover and training, patient surveys, incidents and mortality rates. However, some wards were not submitting all the information to this dashboard, which meant that overall performance could not be monitored.
- Senior staff were aware of those wards not submitting performance data and acknowledged this was due to the high workload of senior and ward based staff, and no further action had been taken.

Medical care (including older people's care)

- Some wards had not submitted data for three months, therefore at both divisional level or board level the performance of these wards was unknown.
- Clinical governance committees recognised that patient falls were the highest amount of incidents in medicine, but incidents were falling mainly due to the training of staff. Second was pressure ulcers, but these were from the community so discussions were taking place between the trust and care homes, although fifth highest was hospital-acquired pressure ulcers, and the clinical governance committee felt this was mainly due to a lack of staff in some areas. Third was staffing levels and, although there was a high recruitment drive, there was also a high turnover of staff.
- The trust recognised the good patient experience survey performance, which was improving and had a good response rate as well, but there were issues with information leaflets, staffing vacancies and mandatory training, and there was a poor score in the emergency assessment unit.
- The trust recognised there were issues with completion of patient records as times were not being recorded, signatures were not recorded, corrections were not signed and changes to patient pathways were not recorded.
- They stated that they achieved 92% overall, in the safety thermometer compliance however, not all wards were completing and submitting this information and so this figure was not an accurate reflection of care in the trust.
- Mortality was improving and was within the expected range
- Senior staff on the wards were not always aware of their risks. There were individual risks in ward managers' offices and some risks such as safety thermometer and record completion were discussed at some ward meetings. Senior medicine leaders acknowledged that there were issues with mandatory training being below 50% in some areas, and felt this was due to the high amount of admissions. An action plan was in place to address this and we saw evidence that mandatory training rates had improved slightly in recent months, but figures were still very low in some areas.

Leadership of service

- Staff reported not receiving feedback when they highlighted concerns, such as low staffing numbers. We saw some actions had been taken to reduce incidents such as visible safety crosses but these had not been fully implemented.
- Staff reported not feeling supported with putting together and submitting business cases to make improvements. Other senior staff described how they sometimes had to bypass the normal process and go straight to the medical director to get cases approved.
- Matron's duties were not prioritised to ensure fundamental issues of care were prioritised at the right level. Matrons were asked to prioritise strategic work over ensuring care was harm free. This meant that floor staff were not fully supported in their duties.
- The trust had planned to open the new acute medical unit (AMU) in December which would have increased the number of hospital in-patient beds by 46, however, as the trust had not been able to close the contingency wards open from last Winter it had recognised the need to make one of these permanent. There was confusion at all levels whether all three wards were to be permanent wards and would be staffed with permanent staff or just one ward. Some staff told us they expected all the wards to remain open as the new AMU would only deal with their winter admissions whereas senior staff hoped they would be able to close one of their temporary wards.

Culture within the service

- Most of the NHS Staff Survey (2013) results put the trust within the top 25% of NHS trusts. However, they were lower than average for discrimination, equality and diversity, and bullying.
- In medicine, they performed poorly on training and experiencing violence and bullying / abuse, but well on appraisals. They performed around average on questions relating to people's jobs, such as team working, job satisfaction, management, quality of the organisation, health and wellbeing and leadership / career.
- Just over 60% of staff in the NHS Staff Survey (2013) would recommend the trust as a place to work which is around the national average.
- Overall, sickness rates for the medicine wards were worse than average in the trust at 5.49% and there were high rates in the haematology and gastroenterology

ward (14.52%), respiratory and endocrinology ward (12.68%), the stroke unit (8.1%), rehabilitation ward (7.97%), cardiology ward (7.44%) and the winter pressure wards at 6.8%.

- Staff reported being destabilised by the changes in matron they reported to with staff saying they had reported to four different matrons in the last two years.
- Some senior nurses told us that, although the recruitment push was bringing in additional staff, they were losing either as many or more than those they recruited.
- Staff reported receiving good support within their team. However, all the matrons and some of the ward managers we spoke with felt overworked, stressed and overstretched, as they were having to cover a number of wards at the same time.
- Band 6 staff were responsible for some wards with only Matron nurse support when other wards had band 7 nurses with support from band 6 nurses. Most staff reported feeling stressed due to the workload pressure and the amount of staff they had available. They reported this was particularly high, due to the amount of times staff were moved between wards to cover over areas. This happened as there were no substantive staff on those wards, with only agency staff on the wards until they were able to cover.

Public and staff engagement

- The NHS Friends and Family Test response rate was better than average at 42.8% but the score was below average at 64.
- Staff stated that they felt engaged in how the trust was performing and changing as well as within their own specific ward or speciality, but they were unable to tell us how well they were performing or what their ongoing risks were.
- Team meetings occurred only when there was time, rather than being scheduled in. Two wards had only two meetings in six months, at these meetings they discuss recent incidents and safety issues with actions put in place, but there was no note of any open discussion by the team.
- Another ward did openly discuss issues and concerns as well as performance, and had had three meetings in nine months. The only meetings that occurred regularly were with senior staff and above, as weekly matron's meetings were often cancelled. Staff commented that there was sometimes an issue with information from trust level reaching front line staff.
- Some staff expressed that they felt the trust focus was only on achieving the A&E targets.

Innovation, improvement and sustainability

- Both the gastroenterology and haematology and the dementia-friendly wards had been specially designed. The gastroenteritis / haemo-oncology ward had all beds in single en-suite rooms. The dementia-friendly ward had been designed and developed taking into account how colour can enhance the environment and to make the environment easier to navigate for patients living with dementia.
- Senior staff expressed concern that the trust was only reacting to events and admissions rather than planning for them.

Surgery

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

Information about the service

The hospital treated 12,400 cases within the surgery division in 2013/14. It included 16% of planned, 38% emergency, and 46% of day case surgical procedures. The majority of cases in the hospital were treated within the general surgery (35%), trauma and orthopaedics (17%) and ophthalmology (14%) specialities.

We visited theatres, anaesthetic rooms and recovery areas, male and female day case units, and post-surgical wards. We also visited interventional radiology services and the preoperative assessment unit.

We spoke with eighteen patients, seven of their carers and relatives and 60 members of staff, including doctors, nurses, allied healthcare professionals, ward managers, senior staff and other support staff, such as cleaners or ward clerks. We reviewed patient and medication records and observed care being delivered on the wards and in theatres.

Summary of findings

We found that there were insufficient staff on surgery wards and some nurse and healthcare assistant shifts were left uncovered. Medicines were not managed safely and the premises were poorly maintained. Patients did not have access to interventional radiology seven days a week. Elderly patients were not screened for dementia.

There was a long waiting list for a urodynamics study in the urology department and we observed that beds on the day case unit were used for patients who were to stay overnight. Overall, systems were not sufficient to adequately ensure that service quality was monitored.

We also noted that the hospital had consistently met the referral to treatment targets. Procedures used for reporting errors, incidents and near misses were effective. There was good communication between all staff involved in patient care and treatment.

We observed that staff were caring and that all spoke respectfully to patients. Nurses and doctors were friendly and treated patients with compassion. Patients felt involved in decisions about their care and treatment.

Surgery

Are surgery services safe?

Inadequate

Patient safety was compromised, as the hospital was unable to cover some shifts with nurses and healthcare assistants. Medicines were not managed safely. Many of the staff had not completed their mandatory training.

We observed that not all areas were clean and the hospital did not meet infection control and prevention standards. The trust did not assure effective use of the World Health Organization surgical safety checklist within the interventional radiology unit.

We found that patients were asked appropriately for their consent prior to procedures being carried out. Staff knew how to report concerns related to alleged abuse or neglect should there be the need. Procedures used for reporting errors, incidents and near misses were effective.

There was no record of assurance for the performance of theatre ventilation systems.

Incidents

- There were two never events (serious, largely preventable patient safety incidents, which should not occur) regarding retained swabs in maternity theatres. In response, the trust commissioned an audit of all theatres in February and March 2014. It included an audit undertaken by an independent experienced operating theatre nurse and an audit of policies and processes conducted by internal auditors.
- The observational audit concluded that theatre practice was safe. Recommendations were made in relation to compliance with the World Health Organization (WHO) surgical safety checklist. An action plan was developed by the surgery division and the progress with it was monitored by the trust's board and quality and risk committee. Monthly audits of the WHO surgical safety checklist's use in theatres indicated improvements had been made regarding the checklist compliance.
- Three incidents were reported within the surgical division through the Strategic Executive Information System in 2013/14. We observed that incidents were adequately investigated and root cause analysis had been completed with learning points identified.
- Anaesthetic incidents were adequately reported and monitored. We observed that there were no noticeable trends or patterns of incidents.
- Safety alerts were monitored and nurses we spoke with were aware of the most recent critical safety alerts that were relevant to their specialities.
- The hospital reviewed deaths to ensure that patients were not dying as a consequence of unsafe clinical practices. The mortality and morbidity meetings took place monthly at speciality level and were led by a speciality mortality lead. Surgical division morbidity and mortality meetings did take place, however, the reporting of these meetings was not formalised to allow learning and actions to be captured. The trust had completed a trust-wide mortality audit in April 2014, which highlighted that learning from mortality cases needed to improve.
- An action plan recommended that the divisional quarterly reports should be shared at the quality and risk committee and clinical governance forums.
- Nurses and doctors told us they had not always received feedback in response to minor incidents reported by them through the trust's electronic reporting system. However, they had heard about major incidents, such as coroner's inquests, and 'lessons learnt' had been communicated with them. All staff told us they felt able to raise concerns and knew how to do it.

Safety thermometer

- Pressure ulcers, falls and catheter-related urinary tract infections (UTIs) numbers were low in 2013/14.
- There were no venous thromboembolism (VTE) cases (deep vein thrombosis and pulmonary embolism) reported on surgical wards. The hospital reported two catheter-related UTIs, eight falls and twelve pressure ulcers (five grade 4 and two grade 3) on Kennedy ward - August 2013 to August 2014.
- Not all of the patients had been assessed in relation to the risk of venous thromboembolism (VTE –deep vein thrombosis and pulmonary embolism) as required by the guidance on reducing the risk in patients admitted to hospital. NICE recommends that all patients should be assessed for the risk of developing thrombosis (blood clots or a VTE assessment) on a regular basis. We observed that the hospital did not fully comply with this

recommendation. Many VTE assessments, across all surgical wards, were not completed, some were not dated and others did not include a name of person carrying it out.

- Only in three cases were the pressure ulcers acquired in the hospital. Jersey ward had reported seven falls, one catheter-related UTI and six pressure ulcers during the same period, four of those pressure ulcers were hospital-acquired.
- There were no pressure ulcers and four falls reported on Lister ward. We observed three catheter-related UTIs reported by the ward, with two that were newly developed while the patients were being hospitalised.

Cleanliness, infection control and hygiene

- There was insufficient evidence to assure us that a safe, clean, compliant environment for surgical procedures was provided at the hospital.
- A direct expansion air conditioning unit was used in theatre 2 to cool the air supplied to the room. The use of unit in this environment is not recommended, due to risks associated with the cleanliness of recirculated air. Theatres 1 and 7 were of 'ultra clean' classification. These theatres contained highly efficient filtration and a laminar flow of air over the operating table. Cleaning of the ductwork internals was undertaken in May 2014.
- Revalidation of these two theatres was also undertaken in May 2014 and it was consistent with the requirements as prescribed by Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises - which provides guidance on the design and management of heating and specialised ventilation in health sector buildings.
- Theatres 2 to 6 had conventional general operating theatre ventilation. No records of the commissioning or annual revalidation of these theatres were provided by the trust.
- There was no record of assurance for the performance of these theatre ventilation systems. The theatre ventilation did not feature on the estate's risk register. The trust told us a review of the theatre's ventilation systems and the associated plant room had been carried out shortly after the inspection.
- Cleaning audits were carried out on a monthly basis by ward managers. Records indicated that all hospital areas achieved or surpassed their target compliance figures with theatres achieving 98%, day-care units and surgical wards achieving above 96% in August 2014. Patient-led assessments of the care environment (PLACE) scores for the hospital for cleanliness (91%) in 2014 were worse than the national average of 97%. We did not have information on how this related to individual wards.
- We observed that Marina ward appeared to be bright and clean. Windows on Jersey and Kennedy ward were dirty. The facilities management team were unable to provide any assurance as to when the windows were scheduled to be cleaned next or when they were last cleaned.
- We found dust on surfaces and some equipment used in operating theatres and prep rooms; including an operating microscope and anaesthetic machines. Recovery areas appeared clean.
- We observed that some of the beds used in the day unit and chairs used in ophthalmology theatres had their upholstery damaged. In consequence, they were not capable of withstanding disinfection or impervious to contamination.
- We observed that disposable curtains around patient bays were clean, they had a date for changing on them and all were in date. Non-disposable curtains were used at main windows on surgical wards. We could not verify whether a changing regime was being followed as recording was inconsistent.
- Personal protective equipment, such as gloves and aprons, was available for staff to use whenever necessary. We also observed that hand hygiene practice was appropriate. There was a sufficient number of hand-washing basins. There were hand sanitisers available in corridors and near each of the patient bays.
- The trust's MRSA policy required all emergency and relevant elective patients to be screened for MRSA - a type of bacterial infection that is resistant to a number of widely-used antibiotics.
- An audit completed in April 2014 indicated that there was 100% screening compliance on surgical wards for elective cases. Day case units were not included in the audit.
- Theatre recovery staff screened emergency orthopaedic patients. There was, overall, 90% compliance noted for emergency cases, with the worst rates recorded on Marina ward (83%) and the best on Jersey ward at 96%. The trust planned future audits, which would include day care and maternity caesarean sections.

- There were no MRSA infections reported for the surgery division in 2014. One patient was confirmed to be infected with C. difficile bacteria. If patients tested positive for MRSA at the preoperative assessment stage, they were usually treated for MRSA before the surgery.
- There were only a small number of total hip replacements cases done at the Hillingdon Hospital site, with most of them being performed in Mount Vernon Hospital.
- The hospital completed regular audits that covered the preoperative period to check if patients were screened for MRSA and post-surgery to check if the body temperature and glucose levels in diabetic patients were adequately maintained, in order to minimise the risk of a SSI.
- An audit completed in July 2014, indicated preoperative actions were completed correctly in 93% of all cases. Most of the perioperative actions were also adequately performed. Hair was removed with clippers using a disposable head, patients' skin was prepared with antiseptic and appropriate dressings were used. However, the audit indicated that glucose levels in theatre and recovery areas were not adequately measured and maintained. This could put patients at an increased risk of getting a SSI.
- Surgical instruments were collected for central sterile processing off site. Theatre staff told us they were satisfied with the quality of service provided.
- There were link nurses responsible for taking responsibility for infection prevention and control (IPC) on surgical wards or in theatres. However, staff did not know who these link nurses were. All audits were carried out by the trust's IPC team.

Environment and equipment

- Scores from the 2014 patient-led assessments of the care environment (PLACE) for condition, appearance and maintenance were 82%, worse than the national average of 92%. We did not have information on how those scores related to individual wards.
- The rooms within Marina ward had been redecorated in 2014 and appeared to be bright and clean. We noted that the main corridor floors showed compaction damage in small, but numerous areas. The damage had compromised the integrity of the floor covering and could not be cleaned or disinfected effectively.
- Some of the windows on surgical wards did not close properly and patients told us they could feel wind coming through the gaps. We saw duct tape was being used to prevent drafts. The director of estates told us of a business case, which highlighted risks relating to maintenance regimes, had been developed, which set out a clear programme of improvements. We were also told that a capital project had been initiated to install secondary double glazing on surgical wards.
- We observed that the terrazzo flooring used throughout the general operating theatres had cracks and minor gaps that were hard to clean and could harbour bacteria. In addition, the floor edge trim in corridors was not sealed and, in many areas, wall plaster was damaged.
- In some recovery areas paint came off the wall exposing wall plaster. Timber-fitted furniture in preparatory rooms showed signs of wear and would be difficult to clean appropriately.
- We found expired disposable and non-disposable surgical supplies mixed with those that were in date and ready to be used, including a tip less stone extractor, retractors, forceps and clamps.
- There was a lack of routine audit and stock checking to ensure out of date stock was disposed of. Shortly after the inspection, the trust told us that all stock had been reviewed and expired items were removed. We were also told that monthly stock checks had been introduced.
- There was insufficient storage within theatres, scrub rooms and recovery areas. Equipment was stored in corridors and prep rooms and, in general, the environment looked cluttered. Entrances and exits to some of the rooms were obstructed. It included a scrub room and one of the recovery rooms. There were theatre table accessories and computer screens, among other pieces of equipment that were stored in one of the scrub rooms. A cupboard in an anaesthetic room was used for food storage.
- Oxygen cylinders and fire safety equipment was checked, in date and ready to use. Emergency medication and resuscitation trolleys were checked daily on all of the wards we visited. However, on Kennedy ward, the emergency injection pens, which were to be used for severe diabetic hypoglycaemia had expired in August 2014. We brought it to matron's attention and were told that they had been replaced on the day of the inspection.
- The Association of Anaesthetists of Great Britain and Ireland recommends a pre-use check on anaesthetic

equipment to ensure the correct functioning. A record should be kept with the anaesthetic machine to show that these checks are completed. We observed checks had not been recorded as recommended at the hospital. The log book in theatre 3 indicated that the last check of the machine had been completed a week prior to the inspection. Theatre staff told us checks were carried out, but they were not always recorded in log books provided.

Medicines

- The trust had not completed the NHS Protect medicines security self-assessment tool and medicines storage did not comply with the standards set out in the published guidance. We saw medicines stored in cupboards that had had their doors removed in rooms adjacent to theatres. Those rooms were unlocked and could be accessed from the main corridor.
- Other medicines were stored on worktops in recovery areas, or in the aesthetic room. Names of medicines used on labels on shelves in theatres did not correspond with the medicines stored on them. We observed that newly delivered medication on Kennedy ward was left unattended on the nurses' desk for approximately two hours.
- The temperature of the fridge, where medicines were stored, was not always routinely checked. The temperature of the fridge used in theatre 4 was checked only on eight occasions during the month of September. The temperature log in theatre 3 indicated the fridge temperature range was above the recommended threshold, with the maximum temperature recorded at 15 degrees.
- Similarly on Kennedy ward, although the fridge temperature was within the safe range, the log indicated the maximum fridge temperature was at 18 degrees in August and September 2014. The temperature monitoring log was incomplete, with frequent gaps across both months.
- Non-compliance with legislation and trust medicines policy was noted on the divisional risk register. It related to storage of anaesthetic drugs in anaesthetic rooms and the storage cupboard in theatres, including the maternity labour ward theatre. We observed that the control measures put in place to mitigate the risk, such as controlled access to the general areas, CCTV at the entrance, and bi-weekly pharmacy checks, were not sufficient to ensure safe management of medicines.
- The trust had responded to the 2010 National Patient Safety Agency rapid response alert: Reducing harm from omitted and delayed medicines in hospital. Medication incidents were reviewed by the medication safety committee, however, the trust did not carry out an annual audit of omitted and delayed critical medicines as advised by the guidance.
- Trust policy did not allow agency nurses to administer intravenous (IV) medicines and bank nurses could only do so after they had completed their training. Nurses told us this could cause delays in the administration of IV medicines when there was a high proportion of agency staff on duty. On Marina ward there was only one nurse on duty able to give these medicines and support had to be requested from an adjacent unit to ensure patients received their medicines in a timely way.
- There were effective systems for monitoring stock and the use of controlled drugs with checks taking place twice a day. However, systems failed to ensure all stocked medicines were in date. We found out-of-date medicines in one of the anaesthetic rooms and on Kennedy ward.

Records

- The hospital used a monthly clinical effectiveness checker for adult inpatients, to monitor record keeping on the wards. This was designed to check if records included accurate and up-to-date information and whether falls and pressure ulcer assessments were completed.
- It was used effectively on Marina ward, but was not used consistently across all wards.
- Falls risk assessments were not appropriately completed on Jersey ward for patients at high risk of falls. The falls risk assessment form for the ward to use, advised staff to complete additional falls care plan (B) for all patients at high risk. However, staff told us there was no additional falls care plan they could complete and no additional detailed risk assessment forms that were used to minimise the risk of falls.
- The Department of Health requires that VTE risk assessments take place for every patient, and that results are closely monitored. Only some VTE assessments were fully completed on Marina ward. Most of the assessments on Kennedy and Jersey wards were

unfit for purpose. They were undated, not reviewed after 24 hours, as required, and in many cases the patient's name was not recorded, as staff did not put a patient's name sticker in the place provided.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff explained the patients' treatment options and the risks and benefits of the proposed treatment during the preoperative assessment clinics. Some patients were required to sign the consent forms during the assessment (gynaecologic surgery), while others were consented on the day of the surgery (orthopaedics). Consent was also obtained on the day of surgery for patients who had consented at preoperative assessment.
- An overview of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards was provided to all staff during the one hour training for safeguarding adults, delivered every three years. We observed low (49%) compliance with this training among staff working within the surgery division.
- Only 6.6% of staff had completed bespoke classroom-based Mental Capacity Act 2005 and Deprivation of Liberty Safeguards training. Risks related to low compliance with training on Mental Capacity Act 2005 and Deprivation of Liberty Safeguards were recognised by the trust and it was highlighted on the trust's risk register. Nurses told us this training was not mandatory and it was often challenging for staff to be released from clinical areas as mandatory sessions were prioritised.
- There was no learning disability liaison nurse in post. The head of safeguarding had developed links with the learning disability service provided by the local authority, and nurses from the local authority were available to support medical staff if a mental capacity assessment or best interest assessment needed to be completed.

Safeguarding

- Staff were aware of who the safeguarding lead for the trust was and how to report concerns related to alleged abuse or neglect. There were dedicated safeguarding intranet pages where staff could access required information.
- We observed that only 65% of all staff working within the division were up to date with safeguarding training.

Mandatory training

- The hospital worked to achieve a compliance rate of above 80%, with mandatory training across all of the departments. Training for staff working within the surgical pain service, orthotics, oral surgery, ophthalmology, general surgery, anaesthetics and those on Kennedy and Jersey wards failed to meet this target. Training for staff working in theatres, surgery admin and access teams achieved compliance rates of better than 80%.
- 93% of all staff working within the surgery division had completed basic life support training with 70% of staff completing advanced level training. 94% completed infection control and prevention training. 95% completed corporate induction and 90% completed health and safety training. However, there was a low training uptake for fire safety awareness (59%), moving and handling (60%) and information governance (64%), which were mandatory for all staff.
- Training time was not always allocated to staff. Nurses told us they were asked to complete e-learning courses while on shift during weekends or late shifts when they were less busy.

Assessing and responding to patient risk

- National Early Warning Scores (NEWS) were used across the hospital to assist staff in the early recognition and escalation of a deteriorating patient. We saw that NEWS documentation was mostly appropriately completed. The Situation, Background, Assessment, Recommendation (SBAR) framework was used to support staff in escalating concerns in a clear and concise manner. Staff were familiar with those tools and knew how to escalate concerns related to patients' wellbeing.
- Two weeks prior to the inspection, Lister ward had been open as a 16-bed surgical escalation unit. There was no clear admission protocol, focused on acuity level, to support appropriate admission to the ward. While Lister ward was a general surgery ward, we observed that there was a need to increase bed numbers for trauma and orthopaedic patients. Approximately ten trauma and orthopaedic patients were cared for on another general surgery ward at the time of the inspection.
- Doctors said they were frequently required to visit surgical patients on medical wards. The trust told us

that approximately 2.5% of surgical patients in June 2014 were placed in other departments' wards due to the lack of beds. Surgical patients were frequently placed on the elderly medicine ward.

- There were inadequate quality control measures to ensure risks related to medicines management and premises, or to ensure all staff working within the division had completed mandatory training.
- We observed that patients on the wards had call bells within their reach and these were responded to promptly.
- As indicated by the Hip Fracture Audit 2013, 97% of patients admitted with hip fracture had a specialist falls assessment performed. It was in line with the England average. The trust had improved their results when compared with the previous year from 94%. On Jersey ward, falls assessments were not appropriately completed for patients at high risk.
- The World Health Organization (WHO) surgical safety checklist was in use in operating theatres. The trust audited the use of the checklist in June, July and August 2014, following on from recommendations of audits of the maternity theatres carried out in February and March 2014.
- We observed that compliance levels had steadily improved over those three months. Compliance levels near 100% were reported for colorectal surgery, pain, and vascular surgery. However, the audit indicated the 'sign out' section was not always completed for orthopaedics (73% in August 2014) and urology at 60% completion in July 2014.
- The trust did not assure effective use of the WHO surgical safety checklist within interventional radiology, as no audits were included in this department. We observed that all three steps of the WHO surgical safety checklist had been completed (sing in, time out, sign out) and the procedure appeared well embedded in staff practice.
- However, there were no formal briefings or debriefings. The addition of team briefing and debriefing sessions at the beginning and the end of theatre lists is advocated by the 'five steps to safer surgery' procedures (Patient Safety First campaign) and the National Patient Safety Agency (NPSA) as an addition to the WHO surgical safety checklist.

Nursing staffing

- Overall, nurses and doctors felt wards were understaffed. Nurses on Marina ward told us they experienced pressures and felt they were "over reliant" on agency staff. A senior nurse told us they had high numbers of vacancies and it was increasingly difficult to cover shifts with bank or agency nurses.
- Theatre staff told us they had experienced delays in discharges to the ward as Marina ward's staff were unable to transfer patients promptly. It caused occasional delays as recovery beds were occupied for longer than necessary.
- Nurses on day-care units felt they required an additional healthcare assistant on each of the units. Patients on Kennedy and Jersey wards told us staff appeared busy and that they felt "there were not enough of them".
- Two weeks prior to the inspection, Lister ward had been open as a 16-bed surgical escalation unit. It was staffed by two full-time nurses delegated from other surgery wards who were supported by temporary staff. Nurses felt the trust did not pre-plan adequately to ensure the ward was staffed accurately prior to opening it. Staff felt the decision was taken "in a hurry" without understanding and planning for the impact on other wards' staffing levels.
- There was a shortage of operating department practitioners (ODPs). Approximately two out of seven ODPs working each day were agency staff. We were told it did not impact on patient care, as the theatre manager was able to fill all shifts and that most of the temporary staff used were familiar with the hospital.
- Overall, in July 2014 the trust reported approximately 81% of the average fill rate for nursing staff and 96% for healthcare assistants during the day. Staffing levels at night varied between 98% and 100% or over.
- We observed, overall, very high agency and bank nursing staff use from January 2013 to June 2014. The highest rates were recorded among nursing staff working in general surgery (47%), oral surgery (32%) and on the day treatment wards 26% usage. 15% of nurses working on Jersey ward were employed by an agency or were bank staff. There was fewer bank and agency staff working in theatres at 1%-4%.
- Staffing requirements were not fully met in July 2014 on Jersey ward, with 23% of nurses, and 22% of healthcare assistants – day shifts were left uncovered. Approximately 28% of all nurses' day shifts and 25% of

healthcare assistants' shifts were not filled in June 2014 on the same ward. Nurses on Jersey ward told us they rarely achieved staffing levels as set within the staffing establishment.

- Only 84% of nurses' and 86% of healthcare assistants' day shifts were covered during the same month on Kennedy ward. We observed staffing levels were mostly at an adequate level during the night. It was addressed on the divisional risk register that the actual nurse staffing levels did not always meet the required levels to ensure optimal patient care. Senior managers told us the recruitment programme was underway, with recruitment days held in September and October 2014.
- We observed a high absence rate from June 2013 to June 2014 among staff working in surgical pain service (7.1%) and the theatre 3 at 6.2% absence, which was worse than the trust's average of 2.8%.
- Other departments recorded better than the trust average absence rate including below 1% rate on Jersey ward, general surgery, theatres 4, 5 and 6, the surgical access team and the recovery areas. The risk register indicated that the staff establishment was planned to allow for emergency leave. Matrons reviewed staffing levels on a "shift by shift" basis and reallocated staff across wards.

Surgical staffing

- The majority of the doctors employed by the trust were specialist consultants (34% of all doctors), they were supported by specialty registrar doctors who made up 32% of the establishment. The percentage of consultant and registrar groups was lower than the England average of 40% and 37% respectively. The total number of foundation year one and two doctors (13% of all doctors) was in line with the England average.
- The surgical division employed more middle career doctors (at least three years at 'senior house officer' level or a higher grade within their chosen speciality) when compared with the England average - 20% compared with 11%.
- The Anaesthesia Sprint Audit of Practice (2014) indicated that in 68% of all recorded case the most senior staff present in theatres were a specialist surgeon and a specialist anaesthetist. This was in line with the England average of 69%. In approximately 10% of all cases the specialist surgeon had been assisted by a trainee anaesthetist.
- There was only one surgical junior doctor resident on site from 8pm to 8am. It was either a foundation year 2 or a core trainee doctor. There were similar arrangements within the trauma and orthopaedics on-call team.
- Nurses told us that, occasionally, one junior doctor had covered for both specialities. When a general surgery doctor called in sick. Although the on-call specialty registrar should be available and near the hospital to support the junior doctor, they would not come on site, as they were often scheduled to work on the following day.
- Trainee doctors told us they found it difficult to adjust to working independently at night and felt they would benefit from additional support.

Major incident awareness and training

- The trust had a major incident plan that was reviewed annually. The plan was guided by the Civil Contingencies Act 2004 and the NHS Emergency Planning Guidance 2005. Nurses and ward managers were aware of the emergency procedures, they told us plans had been tested on a number of occasions, including a recent test carried out in 2014.

Are surgery services effective?

Requires improvement

Enhanced recovery programmes were used as recommended by the NHS Institute for Innovation and Improvement.

Patients did not have access to interventional radiology 24 hours a day. Readmission rates for urology, trauma and orthopaedics were worse than expected in elective cases.

Patients were given information about pain and offered pain relief when needed. Patients' nutritional needs were assessed and monitored appropriately. There was good communication across all staff involved in patient care and treatment.

Evidence-based care and treatment

- Enhanced recovery programmes were used for colorectal, orthopaedic and gynaecological surgery, as recommended by the NHS Institute for Innovation and Improvement.

- The trust had a hospital medicines formulary, which listed the medicines the pharmacy stocked, with guidance on prescription practice to promote effective prescribing. We saw this formulary, along with the trust antimicrobial prescribing guidelines were easily accessible to all staff via the trust intranet.
- London quality standards self-assessment indicated the hospital did not achieve standards set for emergency fractured neck of femur operations in 2013/14. Not all cases had been prioritised on planned emergency lists to allow operation within 24 hours of admission to the hospital, as recommended by the National Institute for Health and Care Excellence (NICE) guidance. Not all emergency admissions for fractured neck of femur were seen and assessed by a consultant orthopaedic surgeon, a consultant geriatrician and a consultant anaesthetist within 12 hours of the decision to admit, as required by the guidance.
- The hospital identified difficulties with compliance with NICE guidance for lower limb peripheral arterial disease. This was due to not having resources to effectively measure every patient's ABP (ankle brachial pressure) index and lack of suitable provision for a supervised exercise program. There was no specialist nurse to provide this specialist service. We noted that it was highlighted on the divisional risk register and actions had allocated to address this shortfall, but had not been implemented at the time of the inspection.
- To ensure adherence with the National Patient Safety Agency and the Department of Health guidance the trust completed regular audits to prevent surgical site infections. It covered the preoperative period to check patients were screened for MRSA and post-surgery to check if the body temperature and glucose levels in diabetic patients were adequately maintained. The audit indicated glucose levels in the theatre and recovery areas were not adequately measured and maintained.

Pain relief

- Patients we spoke with had been given information about pain and said someone regularly checked them to make sure they were comfortable and were offered the pain relief when needed.
- 87% of patients participating in the National Cancer Patient Experience Survey 2013/14 said hospital staff did as much as they could to help control pain all of the time.
- London quality standards self-assessment indicated all patients were routinely offered Fascia Iliaca Compartment Block (FICB – a localised anaesthetic) as soon as possible after admission in order to provide them with optimal pain control.

Nutrition and hydration

- Patients told us they were mostly satisfied with the food provided at the hospital. We observed those who had found it difficult to transfer had water and food within their reach.
- Food and fluid intake charts were mostly accurate and up to date, and patients' nutritional needs were monitored appropriately.
- We saw that menus catered for the cultural preferences of patients.
- Patient-led assessments of the care environment (PLACE) score for 2014 for the hospital for food and hydration were 88%, slightly worse than the national average of 89%. We did not have information on how this related to individual wards.

Patient outcomes

- The Hip Fracture Audit 2013 indicated that all patients admitted with hip fracture in 2013 had been assessed for bone protection medication, the England average was 97%. The hospital had improved its results when compared to the previous year recorded at 91%. The same audit suggested that the 22.9 days mean length of total trust stay was longer than the England average of 19 days. It was also longer than the previous year which was 20.6 days. The 30 day follow-up completion rate at 36% was slightly worse than the England average of 39%.
- The trust performed slightly worse than average in the National Lung Cancer Audit , which looked at the care delivered during referral, diagnosis, treatment and outcomes for people diagnosed with lung cancer.
- 84% of patients seen in the hospital had a CT scan before any bronchoscopy procedure, this was worse than the England and Wales average of 90%. 82% of lung cancer patients in England and Wales were seen by a lung cancer nurse specialist (LCNS), and 61% had the nurse present at the time of diagnosis. Access to a LCNS was better than the average at the Hillingdon Hospital at 86% and 82% respectively.
- We noted that, in elective cases, the observed emergency readmissions rate was much worse than expected – this data looks at them number of patients

who present at the hospital less than 28 days post-discharge from the hospital. The number of patients who returned to the hospital within the period were 160 for urology, 139 for trauma and orthopaedics and 118 for general surgery.

- The National Bowel Cancer Audit is a national clinical audit for bowel cancer, including colon and rectal cancer. The number of patients past surgical resection, who were ill and needed to remain as an inpatient for longer than five days, was higher at the hospital (79%) than the England average of 69%.
- The proportion of patients who were recorded as having had a CT scan (99%) was better than the England average of 89%.
- We observed no evidence of risk when analysing the SHMI - summary hospital-level mortality indicator.
- We observed no evidence of risk when analysing composite indicator in-hospital mortality for all specialities, including trauma and orthopaedics conditions and procedures.
- We observed no evidence of risk when analysing the HSMR (hospital standard mortality ratio indicators) from October 2012 to September 2013 for both week days and weekend stays.
- For non-elective treatments in general surgery the readmission rate was better (88) when compared with the England average of 100. For trauma and orthopaedics (107) and urology (108), it was worse than the England average of 100.
- Overall, the hospital's readmission rate for all elective treatments (124) was worse than the average of 101. For non-elective treatments it was better (93) than the average of 100.
- PROM (Patient Reported Outcome Measures) is a programme of evaluation of surgical outcomes based on questionnaires completed by patients before and after their surgery. PROM measures for patients undergoing groin hernia surgery in the hospital were slightly worse than the England average. In 2013/14 more patients than average (31%) reported that there was no change after their surgery. PROM measures for patients undergoing hip replacement were in line with the England average. Measures for knee replacement were slightly better or in line with the England average.
- The number of patients who reported that their condition had improved (49%), or worsened (17%), was slightly worse than the England averages of 51% and 18%.
- For the July 2013 to September 2013 data submission period for total hip replacements and neck of femur, the trust observed an increase in the number of surgical site infections (SSIs). The trust was identified as being outside of national rates, due to four infections for neck of femur.
- In 2013/14 the hospital reported five neck of femur fracture SSIs (out of 169 procedures performed), and three relating to total hip replacement procedures out of 91.
- The increase was discussed at the divisional audit day and infection control committee in January and March 2014. The hospital monitored changes in practice and agreed on actions to minimise the risk of a SSI.

Competent staff

- Staff we spoke with were clear on their responsibilities, aware of patients' individual progress and able to answer patients' questions in a confident manner.
- Most of the nursing and operating department practitioners (ODP) working in theatres were appraised annually. The trust did not provide us with appraisal compliance information for individual departments and wards, but across the trust, 34% of all doctors and 79% of all nurses had been appraised between April 2013 to March 2014. 91% of Allied Healthcare professionals had undergone appraisal during the same period.
- Theatre staff competency training was monitored and planned according to staff roles and responsibilities. It included training on use of specialist equipment and diagnostic tools.

Multidisciplinary working

- We observed that the daily handover meetings were multidisciplinary, attended by specialities teams. The surgery handover meetings were attended by the colorectal, upper gastrointestinal, and breast surgery teams, which included consultants. All junior doctors were willing to be involved with all patients as and when required.
- Daily trauma meetings were organised, where patients admitted within the previous 24-hour period were discussed and a management plan was decided on by the consultant on duty.
- 96% of patients admitted to the hospital with a hip fracture were offered senior geriatric review within 72 hours of admission, this was better than the England average of 87%. Nurses and healthcare assistants told

us they were supported by a geriatrician and a reablement team, who supported patients after their discharge to help them live independently at home after surgery.
- The National Lung Cancer Audit (2013) indicated that fewer patients than expected (95% England and Wales average), were discussed during the multidisciplinary team meetings (87% of cases discussed at the hospital for the period), which would include a surgeon and oncologist.
- Inpatient physiotherapy and occupational therapy had been provided by the team based on Kennedy ward. The team had limited facilities on the ward with the office and the gym used to store equipment. Nurses and healthcare assistants said the team was responsive and they had established good links.

Seven-day services

- There was only one surgical junior doctor resident on site from 8pm to 8am. It was either a foundation year 2 (FY2) or core trainee doctor. The specialty registrar was 'non-resident' and the division director told us they should be no more than 20 minutes away from the hospital.
- The specialty registrar would escalate to the on-call consultant should they need support, or if any patient was being considered for an operation during the out-of-hours period. It could potentially lead to a situation whereby a relatively inexperienced FY2 provided the first surgical opinion. We observed similar arrangements within the trauma and orthopaedics on-call team.
- There have been four occasions, over July to September 2014, where an additional doctor had been booked in response to a significant increase in non-elective activity and increased patient acuity levels. The division undertook a daily assessment of patient activity to establish whether the out-of-hours medical cover was adequate. There was a hospital at night multidisciplinary team able to provide cover across specialties. However, daily handover meetings were not attended by representatives from the surgery, trauma or orthopaedics team.
- One trauma surgery team was working during the weekend with a second team available on call. The recovery team was routinely available until 2am.
- General surgery patients did not have access to an immediately available, fully staffed emergency theatre or a consultant on site within 30 minutes at any time of the day or night. Not all the general surgeon consultants were freed up from elective commitments when on call to allow non-elective patients to be reviewed in a timely way as required by the London quality standards. The standards represent the minimum quality of care that patients admitted as an emergency should expect to receive in every acute hospital in London.
- There were two site management office team members working at night, one responsible for bed management and another one for clinical support. The clinical site manager felt supported by the on-call management team who would come on site should there be a need.
- In September 2014, the hospital performed 20 operations out of hours, with six cases operated on after midnight. The theatre manager told us that the team only operated on critical cases at night as per the published guidance.
- Patients did not have access to interventional radiology 24 hours a day and services were provided Monday to Friday only. The London quality standard requires hospital to provide service within one hour to critical patients and within twelve hours to non-critical patients. Although the reconfiguration of vascular services in the clinical commissioning area reduced the amount of local non-emergency work for interventional radiology, the trust had only two interventional radiology consultants and was unable to maintain an emergency rota. There were no established referral pathways for obtaining interventional radiology support for patients out of office hours, or at weekends. Senior managers told us they recognised network arrangements were fragmented, which posed a risk in the provision of interventional radiology services for patients.
- Pharmacists visited all wards each weekday - Monday to Friday. The pharmacy department was open seven days a week, but with limited hours on Saturday and Sunday. Doctors told us this affected patients' discharges as patients were discharged with a limited, 48-72 hours medicine supply.
- Patients were frequently required to come back to the hospital to receive a full prescription. There were pharmacists on call out of hours, and senior staff on site who had access to an emergency drug cupboard. There was a pharmacy top-up service for ward stock and other medicines were ordered on an individual basis.

Surgery

Are surgery services caring?

Good

We observed that staff were caring and that they spoke respectfully to patients.

Patients told us that nurses and doctors were friendly and they treated them with respect and compassion. Patients felt involved in decisions about their care and treatment.

Surgical wards consistently scored below the England average for the NHS Friends and Family Test with Jersey ward averaging almost 20 percentage point lower than the 12 months national average.

Compassionate care

- We observed patients being treated politely and that their dignity and privacy was respected by the hospital staff. Patients told us "the care was excellent", that staff were "approachable, kind and caring".
- We spoke with a nurse who told us that they always made sure that when patients came back to the day stay unit after their operation, they were served tea and toast, with the tea served in a china cup. They recognised the difference this small gesture made to people post-operatively. We observed this gesture during our inspection.
- The results of the NHS Friends and Family Test for 2013/14 (June to June) demonstrated that Jersey ward consistently scored worse than the England average. The lowest score of 38 was recorded in June 2014 and the average score for the period was 56 against an England average of 74. Kennedy ward scored worse than the England average for ten out of thirteen months. We observed the response rate was better than the England average.
- The trust performed about the same as most other trusts that took part in the national inpatient survey carried out from September 2013 to January 2014.

Patient understanding and involvement

- As indicated in the National Cancer Patient Experience Survey 2014, 78% of all patients who had undergone a surgery said that staff explained how operation had gone in understandable way. This figure was in line with the England average. 81% of patients were also given written information about the operation and 92% said that staff gave them a complete explanation of what would be done. For those questions the hospital scored better than the England average and was among the highest scoring 20% of all trusts taking part in the survey.
- Patients told us they felt involved in the planning of their treatment. Staff at the preoperative assessment clinic informed them of the relevant facts, answered any questions and gathered information about their health. All aspects of the hospital stay, operation and discharge will be explained at pre-assessment. Enhanced recovery programmes were used for colorectal surgery and hip and knee surgeries. As part of the programme, patients were able to play an active role in their care.
- Patients undergoing hip or knee joint replacements were invited to attend the 'joint school' before their surgery, with a family member or friend. This allowed them to find out how they could prepare for their operation and what to expect when in the hospital and once they were discharged.

Emotional support

- The hospital have established user and support groups, many of which are now run by members of the group. This included colorectal cancer group and support group for patients with lung cancer.
- The hospital worked in partnership with a charity, which provided advocacy services offering statutory and informal advocacy services. This was to support people who had mental health needs, learning disabilities and sensory and communication impairments, among others.
- The chaplaincy team was available to patients, their family and friends, to people of all faiths or none. Members of the team visited wards twice a week, or by request at other times. There was a chapel, a quiet prayer room and Islamic prayer room, which could be accessed by patients and visitors.

Are surgery services responsive?

Requires improvement

Dementia screening was not implemented in the hospital. There was a long waiting list for a urodynamics study in the urology department. Trauma and orthopaedics patients' stays were much longer for elective cases than expected.

Surgery

There were delays in patient transfers from recovery to the ward. Beds on the day case unit were used for patients who were to stay overnight. There was only limited, procedure-specific literature available to patients in the preoperative clinics informing them of what the procedure involved and of aftercare.

Theatre lists were checked against surgeons work diaries to avoid cancellations and lists were set accurately. Theatre manager senior nurses and bed coordinators attended weekly list planning and bed management meetings, where surgery sessions were allocated according to patient needs and case complexity.

The hospital monitored the surgery cancellation rate and aimed to achieve a 5% target. We observed the average rate to be at 4.6% from August 2013 to August 2014.

The hospital had consistently met the referral to treatment targets in 2013/14 and performed better than the average English hospital.

Some beds on the day case unit were used for patients who should have been placed on other medical or surgery wards and these patients stayed overnight. Four day case patients experienced delays as they needed to be admitted to waiting areas until a bed became available.

Service planning and delivery to meet the needs of local people

- The hospital had consistently met the referral to treatment targets (RTT) in 2013/14 and performed better than an average English hospital. The percentage of people waiting less than 31 days from diagnosis to first definitive treatment and the instances in which the hospital met their 18 week RTT targets was also better than the average for admitted treatments, non-admitted treatments and for patients waiting for treatment.
- We observed that approximately 97% of trauma and orthopaedics, urology, ophthalmology, oral surgery and general surgery patients had received treatment within 18 weeks in 2013/14 for admitted adjusted pathways.
- The hospital did not have a fully staffed theatre available 24 hours a day to allow staff to perform immediate life, limb or organ-saving interventions within minutes of when the decision to operate was made. There was a gap on weekday mornings, Monday to Friday, from 8am to 1pm. In the acute emergency unit staff were required to interrupt an elective list, resulting in the cancellation of that list and the rebooking the patients.
- London Quality Standards Self-assessment 2013 indicated that patients should have a discharge plan and an estimated discharge date set no later than 24 hours after their admission. Nurses told us discharge summaries were easily accessible and prepared promptly to avoid delays. There was a procedure that allowed access to social services seven days per week.
- Key performance indicators for the pharmacy department for September 2014 showed the average waiting time for a patient discharge prescription was 67 minutes against a target of 120 minutes.
- There was no designated surgical assessment unit to assess patients who had a confirmed or probable surgical condition. A matron told us two patient bays allocated on the Grange ward had ceased to be used for this purpose in 2014. Some patients were admitted to the Lister ward, which was a general surgical 'surge pressure ward' opened in September 2014.

Access and flow

- There were minimal opportunities for ward matrons to be involved in bed management. The clinical site management team was solely responsible for bed management and ensuring patient needs were prioritised, and appropriate treatment and interventions commenced without delays. There were daily bed meetings organised at 9:30am and 11am.
- The preoperative assessment clinics ran consultant-led sessions three times a week. Patients were required to wait up to three weeks to pre-book a routine assessment appointment. The clinic also ran walk-in sessions. However, there was often limited capacity with most of the walk-in slots used for emergency appointments.
- There was a long waiting list for a urodynamics study in the urology department, with up to a year-long wait in some cases, with frequent cancellations and rebooking. The trust was aiming to bring waiting lists down to six weeks. A gynaecology consultant was asked to support the urology department to address the immediate waiting list.
- The utilisation rate for operating theatres between August 2013 and August 2014 was 83%. The hospital was working towards achieving 87% to improve efficiency.

Surgery

- The Hip Fracture Audit 2013 indicated that 89% of patients admitted with hip fracture had undergone surgery on the day of, or day after, admission. This is significantly better than the England average of 74%, but worse than in the previous year's figure of 97%.
- 57% of patients had been admitted to an orthopaedic ward within four hours, this is better than the England average of 48%, but again worse than the hospital's previous year's figure of 62%.
- Overall, seven of ten indicators used in the audit were better than the England average.
- There were eight operations cancelled between August 2013 and August 2014 due to the shortage of critical care beds. When the operations were cancelled due to unforeseen circumstances the hospital was able to reschedule them in a timely manner. We observed that all patients whose planned operations were cancelled, were treated within 28 days in 2013/14.
- Theatre lists were checked against surgeons work diaries to avoid cancellations and lists were set accurately. Theatre manager senior nurses and bed coordinators attended weekly list planning and bed management meetings, where surgery sessions were allocated according to patient needs and case complexity.
- Theatre managers monitored procedure cancellations, such as unexpected medical complications, unexpected staff absences, or problems with equipment. They told us all cases were discussed at weekly meetings with the assistant director of operations. There was a procedure for the escalation of potential cancellations, which required senior management authorisation along with a member of the directorate team.
- We observed high (95%) bed occupancy on Jersey ward and 97% on Kennedy ward from April to August 2014.
- The average length of stay (ALOS) for the hospital in 2013/14 was longer (four days) than the England average for elective cases which is three days.
- Trauma and orthopaedics patient stays were much longer for elective cases (six days) than the England average for the speciality of three days. The ALOS for general surgery and urology patients was in line with the national average.
- The ALOS for non-elective cases was the same as the England average of five days.
- General surgery, trauma and orthopaedic patients' ALOS was in line with the England average for non-elective cases. Urology patients stayed for one day longer than the England ALOS of three days.
- The hospital monitored the surgery cancellation rate and aimed to achieve a 5% target. We observed the average rate to be at 4.6% from August 2013 to August 2014. The lowest cancellation rate was observed for ophthalmology and general surgery at 4.7%.
- The hospital had consistently achieved the 3% target related to patients' non-attendance set by the trust. Between August 2013 and August 2014 1.6% of all patients did not attend their planned operations.
- The medical handover of patients took place twice a day. There were arrangements for the handover of patients at each change of responsible consultant or medical team. Changes in treatment plans were communicated to nursing and therapy staff promptly if they were not involved in the handover discussions. A site manager visited every ward in the early mornings to communicate with the individual teams taking responsible for day-time care.
- The hospital did not comply with the national guidance issued by the Association of Anaesthetists of Great Britain and Ireland, related to recovery room facility. This guidance recommends that the ratio of beds to operating theatres should not be less than two. There was one recovery bed allocated to each bed in the operating theatre (seven in total).
- There were delays in patient transfers from recovery to the ward. Theatre staff told us it was due to the low staff establishment and occasional shortages of staff on Marina ward. Lister ward was also, occasionally, unable to release staff to allow for a patient transfer to take place. In consequence, they were unable to receive new post-operative patients. It was noted on the trust's risk register that a problem with the transfer was experienced on a weekly basis in 2013. There was a plan to extend the recovery area by two extra beds.
- We observed three patients waiting for an extended period of time, to be discharged to the ward for up to three hours. Theatre staff told us that, occasionally, patients were transferred to a day case ward temporarily, to free up recovery beds. The day case ward was unable to meet patient's needs fully, they were unable to provide patients with hot food and only biscuits and scones were available to them There was limited access to toilet facilities.

- Nurses told us they felt that all patients placed on other wards had received appropriate support, coordinated by an appropriate consultant.
- We observed that some beds on the day case unit were used for patients who should have been placed on other medical or surgery wards. On Pagett Ward, which was a 17-bed male day case unit, seven patients were admitted by the site clinical practitioner, who were waiting for a bed on another ward. Nurses told us this occurred frequently.
- Some patients stayed overnight on the ward, but nurses were unable to ascertain how many beds would be used in advance. This impacted on day cases, as procedures lists were planned assuming all day case unit beds were available for day case patients. Four day case patients experienced delays as they needed to be admitted to waiting areas until a bed became available.

Meeting people's individual needs

- Senior nurses told us that patients living with dementia, children and others who required reasonable adjustments and enhanced discharge planning were first on the operation list, giving staff time to arrange discharges.
- There were weekly bed forecast planning meetings organised, which were attended by senior nurses, theatre managers and bed coordinators. We observed that patients' individual needs were discussed during those meetings to allow adequate planning and preparation prior to their admission.
- Staff discussed the need for increased staffing to support a patient living with dementia and equipment availability for another patient with physical disabilities. We observed that staff at the day case unit had limited access to equipment to support people with mobility difficulties, or those with a high body mass index. A senior nurse told us those patients would be identified during the preoperative assessment and arrangements would be made to admit them to one of the surgical wards.
- 99% of patients admitted with a hip fracture in 2013, had been assessed for confusion and other cognitive impairments as suggested by the Hip Fracture Audit 2013. We observed that dementia screening assessments were not routinely completed for patients who required it. There were patients 75 years of age and older on Kennedy ward who had not been screened for cognitive impairments, including a patient who appeared to be confused.
- This was despite the fact that we had been told that Single call access for mental health referrals was available 24 hours a day, seven days a week with a maximum 'in person' response time of 30 minutes.
- The pharmacy department had no facility to supply medicines in multi-compartment compliance aids also known as monitored dosage systems. Patients identified as having medicines adherence issues were not being appropriately assessed to identify the best intervention for their needs. We were told that occupational therapists were able to recommend the use of a multi-compartment compliance aid for patients, but these could not be supplied by the pharmacy department.
- No occurrences of unjustified mixed sex sleeping accommodation were reported by the hospital in September 2014. However, men and women were cared for and slept in the same open ward on Lister ward, which was open in the middle of September. It was a 16-bed surgical, open plan ward used by male and female patients. They did not share toilets or washing facilities.
- We observed that there was only limited, procedure-specific literature available to patients in the preoperative clinics informing them of what the procedure involved and of aftercare. There were no printed materials available in languages other than English. Staff could book face-to-face, or over the telephone interpreters for communicating with patients in other languages.
- The hospital did not meet the requirements set by the Department of Health on eliminating mixed sex accommodation in hospitals. Men and women were cared for and slept in the same open ward on Lister ward, which was a general surgical ward open in middle of September 2014.
- Hillingdon Hospital's patient-led assessments of the care environment (PLACE) scores for 2014 for privacy, dignity and wellbeing (89%) were slightly better than the national average of 88%. We did not have information on how this related to individual wards.

Surgery

Learning from complaints and concerns

- The trust told us that all formal complaints were acknowledged within three working days of receipt. There was a deadline of 30 working days for a full response to be made. The trust had met its complaint response deadline in 73% of complaints received in 2013/14. Learning from complaints was disseminated through clinical divisional forums, charge nurse meetings and ward meetings.

Are surgery services well-led?

Requires improvement

Staff on surgical wards told us team meetings were frequently cancelled due to staff shortages. There were inadequate quality control measures to ensure risks related to medicines management, premises, safe staffing or to ensure all staff working within the division had completed mandatory training. The trust did not assure effective use of the WHO surgical safety checklist within interventional radiology, as no audits were included in this department.

Most staff felt satisfied and motivated. We were told that they were able to express concerns when required. Doctors felt they were provided with good training opportunities.

Vision and strategy for this service

- The trust had introduced 'CARES values' in 2013 to improve staff engagement and patient experience. The values stress the importance of communication, staff attitudes, delivering excellence, recognising diversity and promoting a culture of safety. We found staff we spoke with were well aware of those values and had embraced them. Staff told us they felt the values integrated well with their day to day work.

Governance, risk management and quality measurement

- Staff on surgical wards told us team meetings were frequently cancelled due to staff shortages. There were inadequate quality control measures to ensure risks related to medicines management, premises, safe staffing or to ensure all staff working within the division had completed mandatory training.
- Lister ward had been open as a 16-bed surgical escalation unit, staffed by two full-time nurses delegated from other surgery wards who were supported by temporary staff. Nurses told us that the trust did not pre-plan adequately to ensure the ward was staffed accurately prior to opening it. Staff felt the decision was taken without understanding and planning for the impact on other wards' staffing levels.
- There was a monthly divisional governance board meeting which reviewed and monitored all aspects of patient experience and care. The board reported into the trust's clinical governance committee and the trust quality and risk committee. There was cross-site representation, both managerially and clinically at those meetings. Those meetings were chaired by the clinical director for the division of surgery and anaesthetics, supported by the assistant director of nursing. There were assistant clinical directors for each subspecialty and representatives from audit, health and safety, therapies and governance departments.
- Theatre productivity meetings were organised biweekly. We observed that actions agreed during those meetings were recorded with an allocated timescale and the name of a person responsible for completion. There were theatre audits organised monthly with a half day allocated to them. We noted that theatre management failed to address issues related to suitability of premises, cleanliness and medication storage.
- Each of the wards was provided with key performance indicators to inform them how they performed in relation to safety, patients experience or clinical effectiveness. Senior nurses were aware of how they performed in comparison with other wards and of areas where improvements were required. Key findings and tables were also displayed on wards.

Leadership of service

- Nurses told us the director of nursing and patient experience was visible and approachable and they spoke fondly of them.
- The recovery area was well organised and managed staff working there told us they were provided with "excellent leadership" and that they were happy working at the hospital. Staff on other wards were also mostly positive about the local leadership and well-motivated. With nursing staff at all levels being "friendly and approachable".
- We observed that the preoperative assessment team did not come under nursing governance structure to

allow for clear lines of responsibility and accountability for the overall quality of clinical care. Nurses were accountable to the surgical access manager and to the assistant director of operations.

- Bed allocation was coordinated from the clinical site management office with decisions on where to place patients made by the clinical site practitioners. Matrons on individual wards did not feel fully involved in those decisions and felt communication needed to improve. A nurse on the day case unit told us that managing day case patients was difficult as clinical site practitioners did not take into account day surgery lists when placing people on the day case unit.
- Nurse and healthcare assistants on surgical wards told us team meetings were frequently cancelled due to staff shortages. There were no other alternative forums introduced to support the team.

Culture within the service

- Results of the NHS Friends and Family Test organised for staff from April 2014 to June 2014 indicated that 68% of staff would recommend the hospital as a place to work. 77% of them would recommend care at the hospital. The results are slightly better than the England averages of 62% and 76%. Staff we spoke with told us they would be treated at the hospital.
- Results of the staff survey from April 2014 to June 2014 indicated that 68% of staff would recommend the hospital as a place to work. 77% of them would recommend care at the hospital. The results are slightly better than the England averages of 62% and 76%. Staff we spoke with told us they would "definitely be treated at the hospital".
- Doctors told us they liked working in the hospital and that they had been well supported by the hospital and their colleagues. They also said they were provided with good training opportunities, which met their individual training needs.
- We observed that individual teams worked well together and communicated effectively, they were committed and focused on patients care. Nurses told us they had, mostly, a good relationship with doctors and if they had any concerns they were able to address them directly with the doctors.

Public and staff engagement

- Results of the NHS Friends and Family Test organised for staff from April 2014 to June 2014 indicated that 68% of staff would recommend the hospital as a place to work. 77% of them would recommend care at the hospital. The results are slightly better than the England averages of 62% and 76%. Staff we spoke with told us they would be treated at the hospital.
- Surgical wards consistently scored below the England average for the NHS Friends and Family Test and we saw no other documented examples of the division seeking the views of patients in order to improve the patient experience.

Critical care

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

Information about the service

The intensive care unit (ICU) is a nine bed ward, which offers care to both highly dependent patients and those who are critically ill. The unit admitted just under 500 patients a year aged 16 and above. Children under 16 were admitted in rare circumstances, to be cared for before being retrieved to appropriate specialist units. When we visited, the unit was able to care for up to nine intensive care patients (described as level 3), but was normally configured for five intensive care beds and four high-dependency beds which were level 2. The unit was in an L-shape, with one side room, the long side with six beds and each bed was screened by curtains. The small side had two beds, each also screened by curtains.

The critical care team extended to an outreach team. This was a small team of two and a half whole-time equivalent senior nurses who attended deteriorating patients throughout the hospital on request, and followed up on patients discharged onto wards from ICU. One of the ICU consultant intensivists was the clinical lead for the outreach team.

We spoke with a full range of staff, including consultants, doctors, trainee doctors and nurses from different grades. We met the unit nurse manager and lead consultant for critical care. We spoke with the lead physiotherapist, two of the outreach team nurses, the engineer overseeing ICU equipment, and met the ward administrator.

We spoke with patients who were able to talk with us, and their friends and relatives. We observed care and looked at records and data.

Summary of findings

Experienced and dedicated staff worked hard to ensure the unit was safe. Nursing and medical staffing levels were appropriate in hours, although the rota for full specialist consultant cover was not complete for the out of hours period. The unit had a high retention rate of experienced staff. Some of the routine safety checks were not being done, and there was a lack of local examination and the displaying of patient harm data.

Care and treatment was delivered by trained and experienced staff. Patients, relatives and trainee doctors spoke highly of the unit. There was multi-disciplinary approach to patient care which is essential in all critical care units. Other essential inputs into patient care, such as pain relief and appropriate nutrition and hydration were managed well.

The unit did not conform to modern building standards and had a shortage of space. The facilities for patients and relatives were poor.

Senior staff were committed to their patients, their staff and their unit. However, there was not enough reliable data or audit work to base decisions upon and drive the service forward. A lack of participation in a national audit programme meant data was not adjusted for the inherent risks to patients, and the unit did not benchmark itself against other similar units to judge performance. There was, however, a culture of teamwork and commitment.

Critical care

Are critical care services safe?

Requires improvement

Much of the safety performance of the critical care unit was good, despite an ageing physical environment and a lack of effective governance in some areas. Experienced and dedicated staff worked hard to ensure the unit was safe, although some responsibilities for checking equipment were not in place and this gap had not been identified. There was a lack of local examination and display of patient harm data.

Staff were open and honest in their reporting of incidents, but there was a lack of formal feedback following reporting and any investigations of incidents to underpin improvements and look for emerging trends. Patient records were comprehensive and the risks for deteriorating patients were well managed. National guidelines were in place to ensure changes in patients' vital signs and neurological indicators were identified early.

Nursing and medical staffing levels were good, although the rota for full specialist consultant cover was not complete for the out of hours period. Fully-trained ICU consultant cover was only available for one in every three out of hours shifts.

The unit had a high retention rate of experienced and talented staff.

Incidents

- The unit was involved with a never event in June 2014 (a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented) which related medical compressed air being administered to a patient instead of oxygen. The tubes fitted to the wall outlets had been confused and led to the error. This event had been investigated and an action plan and lessons learned report produced and circulated to all senior staff for onward dissemination to all staff. Staff we spoke with on the unit were aware of the event and the actions taken to prevent a recurrence.
- Serious incidents were investigated and learning shared. We reviewed a serious incident investigation report relating to a patient in the ICU following non-compliance with a patient safety alert. Nursing staff described the learning from this particular incident and demonstrated how practice had changed as a result. This included the production and display of a flowchart to use in the event of the same or a similar circumstances in future.
- A wide range of staff, including all the senior nursing staff, attended a number of meetings to present the findings from both the never event and this serious incident. The serious incident had also been recorded on the hospital risk register. These serious incidents were taken to the critical care forum meeting to be shared among senior staff.
- Staff were open and honest about incidents they reported. There was a trigger list for ICU for incidents to be reported. Nursing staff said this list was a guide and although it was created from experience on the unit, it was not exhaustive, and any incidents staff felt were appropriate were reported.
- We reviewed the ICU incident reports within the trust-wide incident reporting system from 1 September 2013 to 30 September 2014. Incidents included patients being admitted with pressure ulcers or, on rare occasions, those acquired on the unit. Staff reported the malfunction of equipment, patient or staff accidents or incidents and late or delayed discharges from the unit.
- Other incidents included staff errors, such as giving an incorrect dosage of medication or the wrong type. This was an infrequent occurrence. Incidents were reviewed by the appropriate manager and then approved when any review / investigation had been concluded.
- A memorandum was issued to staff with lessons to be learned and action plans to prevent recurrence for some incidents, but we found that incident investigations and analysis were not always fed back to staff in a routine way.
- Staff described feedback as "not very frequent" and "patchy at best". Serious incidents were fed back at meetings, but staff said more general feedback from investigations had not been formalised. Staff said they did not have a sense of any particular trends in incidents, unless they shared information anecdotally with each other.
- Mortality and morbidity (M&M) was reviewed and discussed at unit level, but again these meetings were not formalised and no specific time or date was set aside. Meetings were generally held each quarter.

- There was no discussion of M&M with the wider directorate (surgical) or any incidents escalated through governance arrangements to the trust board.
- At unit meetings, trainee doctors reviewed patients' notes and presented the cases. There were good examples of presentations made to the M&M group by trainee doctors. Learning was used as a teaching aid. No minutes or action plans had been recorded from these meetings in the recent past, although there were minutes recorded for the September 2014 meeting. There were learning points recorded in the September minutes but no action plans where care or treatment could be improved or changed. Clinical staff said some actions arose from the discussions. But without action plans from the meetings, they were unable to determine who was accountable for implementing agreed measures' or whether anything had improved as a result.

Safety thermometer

- Safety thermometer information was mostly unavailable. The nurse manager explained that this information (about avoidable harms to patients) such as the number of falls, unit-acquired pressure ulcers, and venous thromboembolism incidents, was submitted to the hospital trust each week. It was, however, not collated by the unit.
- Apart from some trust-wide data on pressure ulcer statistics, there were no reports from the trust sent back to the unit to examine trends, celebrate good results, or discuss poor results with the staff.
- The data we requested showed there had been 10 unit-acquired pressure ulcers from April to September 2014. There were three category 1 pressure ulcers acquired on the unit (the lowest level of risk) and seven category 2 pressure ulcers. There were no instances of category 3 or 4 (the highest level of harm) pressure ulcers. There was no information about understanding clusters of pressure ulcers (there were three in July 2014) and no comparisons available with other units to understand more about the results. The occurrences for the last four and a half years have increased. Data from the period referred to and previous years was as follows:

Cat 1

Cat 2

Cat 3

Cat 4

2014/2015 April to September

*Slightly different classification to following years

As this data was not collated at unit level, it was obviously not displayed on the unit for patients and relatives to be aware of.

Cleanliness, infection control and hygiene

- The unit had good results from infection prevention and control audits carried out each month.
- Audits took place each month in relation to hand hygiene of nurses; bare-below-the-elbow compliance for nurses; peripheral line care; urinary catheter care; linen audit; environment; medical devices and training of staff. There was, however, no audit to assess the use of personal protective equipment (aprons and gloves, for example) being used or worn. Hand hygiene and bare below the elbow results for medical staff were not recorded on this hospital-wide report. The results for the six months from March to August 2014 showed that most audits achieved above the trust target percentage except for infection control training which ranged from 18% compliance in April 2014 to 64% compliance in August 2014.
- The patients on CCU have not acquired MRSA, C. difficile or MSSA since one incident of C. difficile in December 2012.
- Observation of compliance with infection-control policies and protocols showed good results.
- We observed staff delivering care on a number of occasions, over three days. We saw good evidence of hand washing by nursing and medical staff. Visitors were asked to use hand sanitising gel before entering the ward and there was a clearly marked area with provision of gel before the entrance to the clinical area. All visitors, including maintenance staff, porters and cleaning staff were using the hand sanitising gel and this was available throughout the unit.
- Staff wore personal protective equipment when it was required to do so. Nurses wore aprons and gloves when coming into contact with bodily fluids. All uniforms worn by staff were clean and in good condition.
- Patients were screened for infections. We reviewed details of screening requests made and found screening for recognised infection risks to be carried out regularly

for patients showing symptoms. All patients were screened on admission for MRSA and there was a routine screening for other infections on Mondays, or as required if the patients' condition changed.

- The majority of the unit and equipment used was clean and free from dust. The empty bed space was clean and the date when it was cleaned was displayed. There was, however, some dust on the curtain tracks and on top of the cupboards behind the nursing station. Some areas that needed cleaning were not easily accessible for staff to clean them appropriately as equipment such as chairs and Zimmer frames were in their way. This was due to limited storage space on the unit and as there were no areas available for excess furniture or equipment to be stored.
- It was noted from the minutes of meetings, held before the Care Quality Commission inspection, that staff were instructed to tidy and reorganise the unit, make sure it was kept clean, and to ensure there "was no blood on sharps bins or syringes left". There was a member of the cleaning staff working on the unit each day we visited who was cleaning most areas carefully and meticulously. There was, however, no routine audit carried out on the unit to check the quality of the cleaning programme.

Environment and equipment

- The unit had two standard resuscitation trolleys and a set of paediatric equipment for use on the rare occasion a child was admitted to the unit. Each resuscitation trolley had been checked each day, although there was some confusion over a piece of equipment superseded by a new item and the checklist not having been changed to reflect this. The paediatric equipment was kept in a clinical store room and when we checked the contents we found a number were past their expiry date. There was no procedure for checking this equipment periodically, or replacing expired equipment.
- The ultrasound machine normally located in ICU was used for procedures including the insertion of central lines. The machine was over 10 years old and the screen display was small. Staff told us the machine was sometimes not on the unit as it had been borrowed by other departments. Sometimes the department borrowing the machine was shown on the communication board so the machine could be retrieved, but not always.
- There was no negative air pressure ventilation on the unit or within the side room.
- All new staff had an induction and orientation to the unit. This included the environment, unit security and the facilities. There were checklists for all staff to be followed, including bank, agency and locum staff. Checklists were signed by the new member of staff and the manager or supervisor responsible for their induction.
- The unit had sufficient ventilators to support up to nine patients at any one time. There were eight permanent ventilators and one portable electric ventilator. The ventilators and other essential equipment were checked by nursing staff at each handover session. The ventilators were all registered with the biomedical engineering team and records showed they had been serviced, as required, in the last 12 months.
- The unit had appropriate intubation equipment. An adult difficult intubation trolley had recently been established on the unit and was secured against tampering and checked daily. The equipment had been approved by experienced intensivists specialising in intensive care medicine. It was divided into different trays according to the intubation strategy and equipment to be used with the patient. The unit had a list describing the contents of the trolley and where they were located within it. It was located in a marked area in the middle of the clinical area..
- The equipment on the unit was maintained and serviced as required. We met with the biomedical engineering manager who explained how new equipment was approved, and how new or repaired equipment was supplied and tested before arriving on the wards. Relevant staff were trained in the use of the equipment – generally by the supplier of the equipment. Equipment was given a unique number and held on an asset register. A computer log of all equipment showed when servicing or planned maintenance was due. Maintenance was carried out at least annually and sometimes twice a year, but all in line with manufacturers' guidelines.
- The ICU register showed that all equipment had been serviced in the last 12 months at least. If equipment could not be serviced on the unit, plans were made well in advance to cover the removal of equipment and arrange temporary replacements if necessary. Engineers were on site during weekdays and on call at all other times. The biomedical engineering department were

responsible for ensuring all equipment had instruction manuals either with the department and / or available in the latest relevant version on the trust intranet. The training log in the unit showed that all 42 nursing staff had been trained in the use of each piece of equipment, although there was no formal test or recheck of competency for using the equipment.

Medicines

- The unit had a dedicated pharmacist who attended ward rounds on weekdays. Consultants and nursing staff said a pharmacist or technician visited the unit three and four times on weekdays. There was a pharmacist on duty on Saturday mornings from 8am to midday and then on call at all other times. The unit had good stock levels of commonly-used drugs, which were checked and updated for relevance by a pharmacist on a regular basis.
- Medicines stored on the unit were safely managed, accurately recorded and securely stored. We reviewed a random selection of six of the controlled drugs held in locked storage and found records to be accurate and stocks matching levels shown in the register. The entries in the register were made as required in that the administration was related to the patient and was signed appropriately, new stocks were checked and signed for, and any destruction of medicines was recorded.
- Patients' own medicines could be brought to the unit and would be stored by the patient's bed in a locked cabinet. The pharmacist would check that any brought-in medicines were compatible with those prescribed on the unit. Other medicines held in stock were in locked cupboards with the keys held by the nurse in charge. Those we checked were stored in a well organised state; packaging was not tampered with, undamaged, and contained what was described, and medicines were all within their expiry date. Other clinical storage rooms with fluids and other items at risk from tampering were locked.
- Medicines were safely administrated and patient records we reviewed showed that medicines were given when they needed to be. Any gaps in administration shown on the charts were appropriately explained and those we saw were valid. Administration was signed by two members of the nursing staff.
- The temperature check of the medical refrigerator in the clinical room was not always done consistently. Although there were no records of the temperature being outside of the safe range when checked, there were a number of days each month in 2014 when the temperature was not checked or recorded as required. One of the nursing staff told us there was no clear protocol as to who was responsible for this and nursing staff were not reporting any gaps they found. The checks were also not being audited routinely in order to discover these gaps.

Records

- We reviewed four sets of patient notes and found the nursing and medical notes to be up to date and completed. Current notes had entries into patient care by all professional staff. There was a separate set of notes for physiotherapists, which were clear, legible and relevant.
- Risk assessments and care plans were completed. There were appropriate management plans for patients, which were followed in a timely way.
- Bedside notes and charts were up to date and clear. Vital signs were well documented, along with cardiac and respiratory indicators. Neuropathic indicators, such as pain and pupil reaction were well documented.
- Prescription drug charts were clear and complete. The unit's generic drug chart was used for patients with additional ICU-specific drugs recorded on a separate sheet. This included pre-printed infusion regimes for drugs specific to critical care, to reduce prescription errors. This sheet was attached to the generic trust drug chart on the patients' bedside observation charts. Drugs were appropriately signed for and discontinued drugs were signed and dated at the date of discontinuation and crossed through.
- Patients were given appropriate risk assessments. There were care-plan booklets for different risks. These included the malnutrition universal screening tool (MUST) score, a pressure ulcer risk assessment tool, use of anti-embolism stockings, moving and handling risks, falls prevention, and bedrail assessment.
- Patients were provided with rehabilitation booklets. These were commenced on the unit, passed onto the ward, and then left with the patient when they were fully discharged. If the patient was receiving community care, the booklet could be shared with the visiting therapist.

Critical care

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Appropriate care and treatment was given to patients who did not have capacity at that time to consent to specific interventions. General day-to-day care and treatment decisions, such as giving medications, giving personal care, nutrition and hydration and performing tests were made by the medical and nursing teams. If decisions on more fundamental issues were needed, staff would hold best interest discussions in line with the provisions of the Mental Capacity Act 2005. These would take place with those people who could speak for the patient to hear all the views and opinions on the treatment options. Such discussions were clearly documented in the notes reviewed.
- Patients were able to give their consent when they were mentally and physically able. Staff acted in accordance with the law when treating an unconscious patient, or in an emergency. Staff said patients were told what decisions had been made, by whom and why, if and when the patient regained consciousness, or when the emergency situation had been controlled.

Safeguarding

- Staff had been trained to recognise and respond in order to safeguard vulnerable patients. Mandatory training was delivered and most staff were up to date with their training or it had expired earlier in 2014 and was due for update.
- From data we were provided with, 75% of staff were up to date safeguarding adults training. A further 16% had fallen due in 2014. The 9% of remaining staff (4 staff) had either not had safeguarding adults training, or had been due for an update in 2013.
- Fewer staff had completed their mental health awareness training with 66% of the nursing staff compliant. A further 9% had fallen due in 2014. The remaining 25% of staff (18 staff) had either not had mental health awareness training, or had been due for update in 2013.
- The nurses in charge knew who to contact within the hospital for both adult and child safeguarding. Staff were clear about their responsibilities to report abuse, as well as how to do so.

Mandatory training

Adult basic life support

- Compliant: 28 (64%)
- Now due: 10 (23%)
- Overdue by 12 months: 6 (13%)

Blood & blood products

- Compliant: 34 (81%)
- Now due: 2 (5%)
- Overdue by 12 months: 6 (14%)

Conflict resolution

- Compliant: 29 (66%)
- Now due: 3 (7%)
- Overdue by 12 months: 12 (27%)

Equality, diversity and human rights

- Compliant: 32 (73%)
- Now due: 1 (2%)
- Overdue by 12 months: 11 (25%)

Fire safety

- Compliant: 28 (64%)
- Now due: 3 (7%)
- Overdue by 12 months: 13 (30%)

Health and safety & welfare

- Compliant: 31 (70%)
- Now due: 3 (7%)
- Overdueby 12 months: 10 (23%)

Infection prevention and control

- Compliant: 30 (68%)
- Now due: 2 (5%)
- Overdue by 12 months: 12 (27%)

Information governance

- Compliant: 32 (73%)
- Now due: 2 (5%)
- Overdue by 12 months: 10 (23%)
- The majority of staff had completed their statutory and mandatory training. The unit maintained a matrix of training, which corresponded with trust policy on requirements for statutory and mandatory training and the frequency of required training updates. The matrix was marked to show the date the training was completed. Fields were displayed in amber colour when the training was falling due for refreshing in the next quarter, and in red when it was actually due. Nursing staff we talked with said their statutory and mandatory

training was discussed during their annual review and they were responsible themselves for ensuring it was completed. The compliance at the end of September 2014 for nursing staff was as follows:

Assessing and responding to patient risk

- The nurse in charge of ITU checked each patient, every 12 hours for certain risks. This included pressure area care (the patient being regularly repositioned), bowel management, and the use of the ventilator care bundle - the patient's bed being elevated to 30 degrees, for example, to reduce the risk of ventilator-associated pneumonia.
- The hospital had a policy for management of clinically deteriorating or acutely-ill patients. The policy was based upon the National institute for Health and Care Excellence (NICE) guidance CG50: Acutely-ill patients in hospital. The policy was in date and ratified by the clinical governance committee and based upon the use of National Early Warning Scores (NEWS) to identify patients who were deteriorating.
- The NEWS system was in use throughout the hospital, from implementation in February 2014. The outreach nurses said that the charts for observations, vital signs and oxygen therapy were used for all patients. Each chart had the clinical response protocol and escalation plan attached. This instructed staff what to do when a patient moved from a zero score (no immediate concerns) through a score of one to four points (green) where observations were made more frequently and a registered nurse made aware; five to six points (amber), where frequency of observations were increased to at least every hour and a call placed for urgent assessment by a senior house officer (SHO); Seven or more points (red) where a call was placed for immediate assessment by an SHO and registrar within one hour. The recording of NEWS was also in place in ICU with the same protocols used.
- There was an audit carried out of the use of the NEWS in one 24-hour period in September 2014. This audit picked up a number of incorrect assessments and responses. The audit results were produced and circulated to all ward managers and specific issues fed back at a local level. The audit was due to be repeated every two months. There had been no audits carried-out prior to September, this had been introduced by the outreach team.
- The records for the month of September 2014 were all complete, and in most cases, the name of the nurse responsible for the care of the patient was recorded to provide an audit trail.
- Patients were monitored for different risk indicators. Each ventilated patient was monitored using capnography, which is the monitoring of carbon dioxide in respiratory gases. It was available at each bed on the unit and was always used for patients during intubation, ventilation and weaning, as well as during transfers and tracheostomy insertions.

Nursing staffing

- The number and skill mix of nurses on duty was said by the Nurse Manager to be decided by an acuity tool designed to safely support patients.
- The audit tool we were shown was a matrix starting with the patient's needs in certain areas (respiratory, cardiovascular, renal and neurological), what nursing care was required, the needs of relatives, and any 'special events' for the patient such as theatre visits, tests or transfers. Patients should be scored between one and four points against these areas under clear guidelines. For example, a patient scoring one point for their respiratory needs had spontaneous breathing, routine physiotherapy and no oxygen dependency. A patient scoring four points had, among other things, mechanical ventilation requiring frequent adjustments. Each patient was scored individually.
- All ventilated patients (level three) had a minimum of one to one nursing support. Level two patients had a minimum of two to one support (one nurse supporting two patients). This was in accordance with the guidance of the Faculty of Intensive Care Medicine Core Standard for Intensive Care Units.
- In the rostering data we were shown, there was no evidence the tool was being used. Rather, almost all patients were scored in accordance with their level two or level three dependencies only and none of the other needs. Nursing numbers were then decided on the basis of adding the ratios of 0.5 or 1.0 nurse respectively for each patient.
- There was a good skill mix among the nursing staff. The unit was established for 41.3 whole-time equivalent nurses. The nurse manager was supported by three senior sisters and six junior sisters. One of the senior nurses would be supernumerary on each shift and act

as nurse-in-charge. Nursing staff records showed the sister was not counted in the dependency model. The other staff were band 6 and band 5 nurses. The unit currently did not employ healthcare assistants.

- Although the unit was not using the acuity tool, it was safely staffed on most shifts, in accordance with the core standards. If the unit was full with five level three patients (one to one nursing) and four level two patients (two to one nursing) there would be seven nursing staff on duty. We reviewed the staffing duty rosters for January to September 2014 and looked at particularly busy periods. Most shifts were covered by the requisite number of nursing staff in accordance with the core standards. Bank and agency staff were used during some periods, particularly when staff were on sick leave.
- Agency and bank staff were used to cover vacant nursing shifts. Agency staff had been used for the first time in 2014/2015 as core staff levels had been reduced by five nurses as bed demand had reduced. Agency staff were used to cover periods of sick leave or extended leave. The nurse manager said there was an induction for any new staff, including agency workers, but no specific test of their competency had been devised to be carried out before they commenced a shift. There were, on occasion, just over 20% of agency or bank staff on a shift which was not compliant with the recommendations of the Core Standards for Intensive Care Units, although this did not happen often.
- On the early shift on 10 September 2014, when every bed was occupied, the acuity tool had calculated there were eight nurses needed to safely care for patients. There was one sister who should be supernumerary, four substantive nurses, two of whom were bank nurses. The bank staff, therefore, made up 50% of the staff, and the unit was understaffed by two nurses.
- The outreach nursing team (providing support for deteriorating patients elsewhere in the hospital) saw as many patients as possible and followed up on patients discharged from the unit onto wards. There were, however, not enough outreach nurses to provide full cover overnight, or across the whole weekend.

Medical staffing

- The ICU was consultant-led. There were three ward rounds each weekday, led by the consultant on duty. There was input to the early morning ward round from unit-based staff, including trainee doctors and nursing staff. The midday round was led by the consultant and attended by the pharmacist, microbiologist, trainee doctors, and nursing staff. Other allied healthcare professionals were asked to attend when required. This included dieticians, speech and language therapists, and specialist physicians. The evening handover ward round was led by the consultant with trainee doctors and nursing staff. There was one morning round on Saturdays and Sundays led by the consultant on duty.
- There were some gaps in full specialist consultant cover, which did not, therefore, follow the recommendations of the Core Standards for Intensive Care Units. There were seven consultant intensivists working in rotation in the ICU and another 14 anaesthetists on the on-call rota. There was a minimum of 15 programmed activities of consultant time committed to the ICU each week. However, fully-trained ICU consultant cover was not yet available 24 hours a day, seven days a week.
- This was planned for April 2015 when the lead consultant told us a separate ICU consultant rota would be in place. Currently, ICU consultant cover was from 8am to 6pm on weekdays and 9am to 12 noon on weekends. Out of hours, ICU consultants covered one third of the nights / weekends. There were seven of the 21 anaesthetic consultants, who made up the rota, ICU trained and working regular daytime sessions on ICU. When consultants were on call, their cover was not dedicated to working in the ICU alone, but extended across the whole hospital, including theatres and maternity services. In daytime hours, the consultant covering the ICU did not have other clinical commitments. There were eight trainee doctors also on rotation in the department.
- There was a good consultant to patient ratio. There was one consultant on duty in the general critical care unit for nine beds (which was significantly better than the recommended ratio of one consultant for 15 beds). The consultants were fully committed to the critical care units when they were on duty and did not have other responsibilities within the hospital to attend to.
- Trainee doctors were well supported. They told us there was generally a good, consistent approach by consultants to patient care and support for trainees. Nursing staff were also said to be supportive to trainee doctors and particularly first-year foundation year (FY1) doctors. Trainees spoke in positive terms about the quality of training (on average, they were enabled to attend 75% of teaching sessions), the approachability of all staff, especially the consultants and nurses, and the

collegiate approach to patient care. They often said Hillingdon Hospital was among the most highly respected ICUs and hospitals on the anaesthetic rotation, in terms of training.

- There was a medical workbook for new and returning intensive therapy unit (ITU) doctors. This included subjects such as advanced ventilator strategies, common problems within the ITU, airway management and other typical subjects. There was also an orientation workbook covering the location of documentation and equipment, geography of the site, and governance objectives.
- There was a good use of technology for the sharing of teaching materials and innovations. The hospital used smartphone technology to share protocols and teaching documents with trainees and other staff electronically.

Major incident awareness and training

- The hospital trust had a major incident plan and other relevant policies. The major incident plan had been updated in November 2013.
- There was an action card for the ICU in relation to admissions and discharges in a major incident. Relevant staff had quick access to the plan and had read the requirements for their unit. There was an operational flu plan updated in 2014 and this contained the protocols for ICU if this was put into operation.
- The ICU had a business recovery plan for various situations, including full evacuation of the unit. The recovery plan listed the actions to take and the critical equipment, technology, documentation and consumables to be ordered in order to establish a temporary unit elsewhere.

Are critical care services effective?

Requires improvement

Care and treatment was delivered by trained and experienced staff. Patients, relatives and trainee doctors spoke highly of the unit. The service followed national guidelines, practice and directives. Training and mentorship of junior doctors was appropriate, the consultant presence was sufficient, and their care and treatment was consistent as a team. Some recent national audits had, however, exposed some gaps in nurse training and the unit did not have a dedicated practice nurse educator to constantly improve knowledge.

The unit collected data to determine performance with recognised indicators. However, the unit did not contribute data to the Intensive Care National Audit & Research Centre (ICNARC) and was one of the 5% of adult general critical care units in England, Wales and Northern Ireland who did not participate.

Multidisciplinary team work was well managed, and there was input into patient care from many disciplines. The service had dedicated physiotherapists who worked seven days a week, and there were regular visits each day from the pharmacy team. The ward rounds were demonstrably useful for teaching and demonstrated the patient's individuality.

Essential inputs into patient care, such as pain relief, good nutrition and hydration, were done well. There was a commitment to organ donation and both the clinical lead and specialist nurse had raised awareness and increased the success of transplants made available.

Evidence-based care and treatment

- The unit collected data to determine performance with recognised indicators. However, the unit did not contribute data to the Intensive Care National Audit & Research Centre (ICNARC) and was one of the 5% of adult general critical care units in England, Wales and Northern Ireland who did not participate.
- Key policies were based on recognised specialist guidelines. The NEWS escalation policy was based on the National Institute for Health and Care Excellence (NICE) guidance for acutely-ill patients (CG50) and the Resuscitation Council (UK) guidance.
- On admission, the physiotherapy team used the recognised Chelsea Critical Care Physical Assessment tool to determine a patient's treatment. This was a numerical and pictorial scoring system based upon a composite of 10 commonly assessed components of a patient's physical functions. It was used to set goals for patients and staff to work towards. The assessment was redone when a patient's condition changed and formed part of the decision for a patient's discharge from the unit. Patients were treated in accordance with NICE 83:

Rehabilitation after critical illness, but the unit was not using rehabilitation prescriptions, although this was a recommendation of the Core Standards for Intensive Care Units.

- The unit had contributed to some national audit programmes. Data had been provided to the National Cardiac Arrest Audit for 2013/14.
- There were a number of local audits of clinical care undertaken. This included an audit of ventilator care bundles (VAP bundles), which was designed to reduce the risk to the patient of developing ventilator-associated pneumonia, which was a significant cause of morbidity and mortality in critically-ill patients. Compliance from April to June 2014 was 97% and between 98% and 99% in each quarter of the 2013/14 year.
- There was an audit of assessments for venous thromboembolism (VTE), or blood clots, for which 174 completed from November 2013 to September 2014, only four (2%) were incomplete. The audit for the central line bundles (CVC bundles) was 26 of 33 (79%) central line audit forms showing full compliance in April to June 2014 which had declined slightly from 34 of 42 (81%) in January to March 2014. The target for these audits would be 100% compliance. There was no action plan to address these shortfalls in full compliance or a review of them at unit meetings.
- Compliance with this bundle was, therefore, not showing signs of improvement. However, CVC-related bloodstream infection rates were low, with good methodology used. Data for all positive blood cultures was cross-referenced with CVC tip cultures that were provided by the microbiologist.
- Consultant microbiologists attended the unit each day and met with the ICU consultant and pharmacist as part of the midday ward round. Their involvement was reflected in the good adherence to infection-control practice observed on the unit, and the low nosocomial (hospital-acquired) infection rate.
- Patients admitted to the unit were assessed for delirium. Most nursing staff had been trained in delirium scoring and confusion assessment, or the Confusion Assessment Method for the ICU (often called CAM-ICU), when it was introduced in 2010 and this had been refreshed in 2014. Nurses talked us though the procedure and how patients were monitored for improvements in confusion, throughout their admission. New staff were also trained through the induction programme. Delirium scoring was recorded in the patient records we examined and also checked as part of the 'intentional rounding'. This was a 12-hourly check by a senior nurse on each patient on the unit for certain safety and risk indicators.
- The ICU had an admissions policy based on recognised national frameworks, Department of Health guidelines, and core standards for intensive care. The policy had been produced by the members of the North West London Critical Care Network (NWLCCN), of which Hillingdon Hospital was a member, and was adopted by the units in that organisation to provide local consistency in approach. It had been produced in 2011 and reviewed each year.
- The hospital trust had an organ donation committee, which included the trust chief executive. The trust had a clinical lead for organ donation and was supported by a specialist nurse for organ donation who was attached to NHS Blood and Transplant (NHSBT). The trust was part of the UK National Organ Donation programme and followed NICE guideline CG135: Organ donation for transplantation. The clinical lead represented the trust on the London Collaborative Group on Organ Donation and attended meetings twice a year. There was an educational programme in organ donation rolled out across the trust to relevant staff.
- Audits were undertaken in appropriate departments to identify missed potential donors, and the hospital had achieved a 100% referral rate for potential donors with suspected neurological death in 2012/13 and 2013/14. There had been a drop to 88% in 2013/2014 from 100% in 2012/13 for referrals of potential donors.
- The clinical lead was pleased with the commitment from the hospital to the programme and the trust had been highlighted by NHSBT. The hospital had taken part in the NHSBT National Transplant Week in July 2014 and hosted two 'donation days' at the hospital with a stand and information leaflets. The trust was now committed to working towards the NHSBT 2020 strategy, which was to achieve a world-class performance in organ donation by 2020.
- The unit had recently completed the self-assessment checklist for the recommendations from Tracheostomy Care: On the Right Trach? (2014), a National Confidential Enquiry into Patient Outcome and Death tracheostomy report. Each of the 25 recommendations had been evaluated by the senior nursing and physiotherapy staff.

- Of these 25 recommendations, 11 had been met, seven had been partially met, five had not been met, and two were being further investigated for compliance. Action plans were produced for those areas not met or partially met. Members of staff had been identified to take ownership of the delivery of the action plans. Examples of actions included production of a tracheostomy box for use when transferring patients, and a patient passport. There were to be completed in October 2014 and January 2015 respectively.

Pain relief

- Pain relief was well managed. Patients who we were able to talk with said they had been asked regularly by staff if they were in any pain. Nursing staff confirmed, and we observed, patients who were awake were regularly checked for pain. Pain scores were documented in patient records, using recognised techniques and measures.
- One of the ITU nurses was a specialist nurse in pain management. This nurse was rostered to the unit part time and worked the other half of their time in other areas of the hospital.
- In a snapshot from 10 patients questioned from April to August 2014, eight said staff did everything they could to help control pain, one said staff did to some extent, and the other patient said they did not have pain.

Nutrition and hydration

- Nutrition and hydration was effectively managed. Patient records we reviewed were well completed and safety protocols were followed. Fluid intake and output was measured, recorded and analysed. The method of nutritional intake was recorded and evaluated each day. Energy drinks and food supplements were used for patients who needed them.
- For patients able to take their own fluids, drinks were available on the bedside tables and within reach of patients. Unconscious patients had their circulatory volumes continuously monitored by nursing staff through central venous pressure lines.
- The unit had support from a dietician on weekdays. Nurses said patients were provided with naso-gastric tubes within six hours of admission. Patients provided with total parenteral nutrition feeding (TPN) (nutrients supplied through a central line) were supported by a dietician. The dietician had provided training, information and flow-charts for use on weekends. Nurses said TPN was not started out-of-hours in accordance with hospital policy. Patients were stabilised until a dietician was on duty.
- Patients' nutritional needs were assessed by a dietician. Nutrition regimes were reviewed and adapted appropriately to reflect individualised care.

Patient outcomes

- The unit collected data to determine performance with recognised indicators. However, the unit did not contribute data to the Intensive Care National Audit & Research Centre (ICNARC) and was one of the 5% of adult general critical care units in England, Wales and Northern Ireland who did not participate.
- Participation in a national programme was a recommendation of the Core Standards for Intensive Care Units. The lead consultant and nurse manager said the unit planned to contribute, but there was no timeframe or staff resource identified for this to commence.
- To provide some quality measures, the unit contributed data to the North West London Critical Care Network (NWLCCN) in order to provide evidence of outcomes and benchmark results against other local units. NWLCCN was comprised of 13 hospitals in the area.
- Of the performance measures the unit reported, quality indicators for patient outcomes were good. The data provided showed rates for patients readmitted to the unit within 48 hours of discharge were low. In 2013/14 unplanned readmissions as a percentage of first-time admissions was 2.5% or around 11 patients over the 12 months. In the three months from April to June 2014, there were five patients readmitted, so there was a small increase to 3.6%. This indicated the majority of patients were being discharged from the unit when it was clinically effective to do so.
- Patients spent less time in a critical care bed than average. In ICU in 2013/14 the average length of stay was 2.3 days, which was around half the number of days for other units when considering ICNARC findings of participants' average for 2012/13, at 4.8 days.

Competent staff

- Staff were evaluated for their competence. At the time of our visit, nursing staff appraisals were at 93.18% completed. Nursing staff we met confirmed they had their annual review and that it was beneficial. They said

it considered training and development, their general wellbeing, and achievements. The doctors and consultants we met said the revalidation programme was well underway.

- Nursing staff were trained in subjects relevant to nursing in an ICU. Just over 80% of the nursing staff had completed their mentorship course and this had been updated by the majority of nurses in the last two years.
- There was a high level of nursing staff with a post registration award in critical care nursing. The Core Standards for Intensive Care Units recommended a minimum of 50% of nursing staff should have this qualification. At the time of our visit, 80% of the nursing staff had their post-registration award and this number had been at a peak of 92% in 2013/14.
- Most nursing staff had received training and been assessed as competent in acute pain management, nasogastric tube insertion and the new epidural management protocols. Staff who were not trained or assessed as proficient did not carry out these procedures until they had completed their training. A smaller cohort of senior nurses had been trained in the safe administration of insulin.
- Training sessions were held in the unit on a regular basis. The programmes for April, May and July 2014 included sessions on hemofiltration, tissue viability, and negative pressure wound care. Forty-one of the staff had been in attendance over these three dates. The self-assessment by the unit for Tracheostomy Care: On the Right Trach? (July 2014), the National Confidential Enquiry into Patient Outcome and Death tracheostomy report, indicated nursing staff were not fully trained in the core competencies for the care of tracheostomy patients. There was also only partial training in blocked / displaced tubes / airways and difficult tube changes. These areas were due to be introduced into a formalised training plan by January 2015.
- Time for training was not always taken into account in working patterns. Nursing staff told us that when the unit was less busy, they could use this time for training or tasks unrelated to direct patient care. They told is though that usually, in reality (due to having to cover nursing shortages elsewhere) training was often done at home in their own time but they were able to claim back this time.
- Funding was made available for nurses to take postgraduate qualifications in critical care via external courses.
- The unit did not have a dedicated practice nurse educator. The Core Standards for Intensive Care Units recommended a unit of the size of Hillingdon Hospital should have a practice educator dedicating two-thirds of their time to this role. The unit had practice development nurses who were senior sisters. One only had one fifth of their time given to that role and the other around a third. The training being delivered to nursing staff did not follow an accredited programme from a recognised body.
- The unit had the advantage of the nursing staffing cohort being stable and turnover among nursing staff in the unit being low.
- Trainee doctors were given appropriate teaching on the unit. A two-hour period was used each Wednesday morning for formal teaching with the consultant lead. Depending on the acuity of patients there was also about an hour of other teaching each day by the consultant lead. Sessions had included case reviews presented by the trainees, pharmacology for pain relief, and ventilation strategies.
- Induction onto the unit was, for the two trainees we met, done by a senior house officer in the first instance, and then in depth by a consultant two days later. This included a two-hour session covering equipment and working through an induction booklet.

Multidisciplinary working

- Physiotherapists, pharmacists, speech and language therapists, microbiologists, and the dietician visited the unit regularly. There was a fast response from other specialists, including: ear, nose and throat (ENT), oncology, and renal physicians. There was a consultant ward round in the morning attended by the consultant, trainee doctors and nursing staff. There was a further multidisciplinary round at midday attended by the pharmacist, microbiologist, consultant, trainee doctors and nursing staff. The evening handover round with medical and nursing staff was held between 5pm and 6pm.
- There was a dedicated physiotherapist team on the unit, led by a senior respiratory physiotherapist. The team covered other departments in the hospital, but attended the unit every day, usually in the morning.
- There were three physiotherapists and three assistant physiotherapists. They worked from 8am to 4:30pm each day (including weekends) and were on call at home able to attend the hospital within 45 minutes. At

least two of the team undertook ward rounds each day to review weaning plans, early mobilisation and rehabilitation for patients. They were available on duty at weekends and on-call out of hours. A physiotherapist would also attend the unit out of hours (usually in the evenings) at prearranged times if this was required for a deteriorating patient.

- The critical care team extended to an outreach team. This was a small team of two and a half whole-time equivalent senior nurses who attended deteriorating patients throughout the hospital on request, and followed up on patients discharged onto wards from ICU. One of the ICU consultant intensivists was the clinical lead for the outreach team.
- There was a standardised discharge form to accompany the patient to a ward and to support the outreach nurse. The team also responded to emergency calls for serious events, such as a cardiac arrest. The outreach team's responsibilities were described in the management of the critically-ill patient policy. As well as attending deteriorating patients, they assisted in patient transfers to ICU, provided ward-based training courses to nursing staff; and had audited the NEWS and escalation procedures. The team were available generally from 8am to 8pm, seven days per week, although some shifts were 8am to 4pm if staff were not available.
- The outreach nurses told us they were not able to meet all the requests made upon them and, therefore, prioritised in accordance with risk. There was no plan currently in place to increase provision to full 24-hour cover. When the outreach team were not available, the clinical site practitioners were responsible for responding to deteriorating patients, among their other responsibilities.

Seven-day services

- Consultant ward rounds took place seven days a week. This cover was provided by consultant intensivists and anaesthetists. There was no fixed consultant rota and the seven intensivists at the hospital shared the rota with 14 other anaesthetists, so only one in three weekends were covered by a specialist consultant in intensive care. There were responsibilities for other areas of the hospital also included in the on-call rota.
- Physiotherapists worked 7 days a week.
- The biomedical engineering department were on call at weekends as was a pharmacist. There was no dietician available out of hours.

Are critical care services caring?

Good

Patients and relatives were happy with the care provided. Staff were described as "very caring" and "highly professional". Patients were treated with respect and their dignity was maintained. Patients and relatives were given the information they wanted to have, and staff handled bad news or difficult messages with compassion and understanding. The care we observed from the nursing staff was kind and gentle.

The consultants and doctors were professional, thoughtful and respectful. There was some psychological support available for patients on the unit.

Staff knew their patients well and included them and / or their relatives in decisions

Compassionate care

- Patients and relatives we met spoke highly of the service they received. A patient said of care: "I think it's fabulous," and, "it's really first class." The patient said the unit was quiet at night and patients were able to rest. If there was activity at night, and nurses were aware a patient was disturbed, they would explain what was causing the activity (usually a new admission) and reassure the patient. A relative said the nursing staff were "exemplary" with matters relating to privacy and dignity.
- Staff said they would endeavour to place patients as sensitively as possible in relation to privacy and dignity. The side room would be used if a child under 16 years was admitted prior to transfer or if a patient was at the end of their life and safe to be moved.
- The unit was sensitive to patients' and their relatives' needs. There were set times for visiting hours to allow patients to rest and staff to undertake ward rounds and observations. However, visitors and nursing staff said they would accommodate visitors as much as possible at all times. Relatives confirmed they were respectful of visiting times, but there was no restriction upon them in reality. They said staff were "polite but firm, which is good" when they needed to support the patient and would ask the relative to step outside for a short time. Relatives said the staff explained why this was necessary.

Critical care

- The care we observed from the nursing and medical staff was kind and patient. Nurses talked quietly with patients and reassured them continually. We saw a nurse hold the hand of a distressed patient and the patient repeated "thank you" to the nurse throughout the interaction and was visually calmed. All staff introduced themselves to patients and their visitors. Nurses were observed talking to patients and explaining what care they were delivering even if the patient was not conscious.
- Patients and relatives were able to comment on their care through questionnaires, although there were not a large amount completed. We reviewed the 10 of these completed from April to August 2014. Comments were overwhelmingly positive. Patients said they had 100% confidence in the nursing care. All patients said they were always treated with respect and dignity.

Patient understanding and involvement

- Patients told us they were involved with their care and decisions taken. Those patients who were able to talk with us said they were informed about their condition, tests being arranged, and treatment provided. We observed staff giving good explanations of what was happening and including relatives where possible. This extended to portering staff, who were friendly, cheerful and encouraging. Staff made sure the visitors were identified and only gave information to them if they were entitled to have it, or the patient was able to give permission.
- Patients said they gave consent to care and treatment. Any changes or decisions were discussed and patients said they were able to ask questions about the risks and benefits of any proposed treatment. One patient, who had not been well enough to understand what was happening to them when they were admitted, said they were reassured when everything that had happened to them was gone through by one of the doctors.
- Friends and relatives of patients said they were kept informed and involved with decisions where needed. Relatives we met said they were updated about the patient on each visit to the unit, even if they were very frequent visitors.
- Patient confidentiality was respected. When we were on the unit we did not overhear information about patients where other patients or visitors could easily hear. Patients and visitors said they had not overheard or seen confidential information about other patients. They said conversations with doctors or nurses were either had in areas away from other patients, or with the curtains closed and voices lowered.
- In the 10 questionnaires we reviewed from April to August 2014, nine of the patients said they always got answers from doctors, the remaining person said they sometimes got the answers. Eight patients said they were definitely involved as much as they wanted to be in their care. The remaining two said they were to some extent.

Emotional support

- Patients were able to receive support from two psychologists. The outreach nurse told us of successful referrals to the psychology service and the subsequent improvement in patients' mental health.
- In the 10 questionnaires we reviewed from April to August 2014, all of those patients (seven) who said they wanted to talk to someone about their worries or fears were able to do so. The other three patients said they did not have worries or fears. Seven of 10 patients questioned said they always had emotional support from staff, one said sometimes and one did not need emotional support.

Are critical care services responsive?

Requires improvement

Due to pressures in the rest of the hospital, the intensive care unit was not always able to be responsive to patient need. Some patients were discharged onto wards at night, when this is recognised as being less than optimal for patient wellbeing. This led to delays in patients being able to be admitted to the ward or them needing to be cared for elsewhere.

The ICU was relatively small and, although safe, did not meet the requirements for modern critical care facilities as recommended by the Core Standards for Intensive Care Units. The unit had a shortage of storage space, the bed spaces were small, equipment was not raised from the floor, and facilities for patients and relatives were poor.

Critical care

There was generally a good response from consultants when new patients were admitted, but there was no fixed rota for consultants on weekends, and some admissions were, therefore, done by telephone if the consultant was not on duty.

Service planning and delivery to meet the needs of local people

- The ICU was relatively small and, although safe, did not meet the requirements for modern critical care facilities as recommended by the Core Standards for Intensive Care Units.
- The physical shortcomings of the unit had been recognised by the lead consultant and nurse manager, and there were some intentions to upgrade facilities, but no dates or timescales.
- The trust executive team told us at a presentation that there were plans to expand the ICU, but the detail was not provided.
- Patient and relative facilities were poor. The room was divided into two areas with a seating area at the front and a small room at the rear with a single sofa bed. This sleeping area had a window with no screening. There were no toilet facilities nearby without accessing the unit through a locked door. There was a locked entrance door, but there was no reception area for visitors to the unit and all visitors would need to enter the clinical area before being able to meet staff.
- There was nowhere for visitors to meet with staff in privacy beyond the visitor's waiting room, which was just off a public corridor, or staff offices. There was only one patient toilet in the unit and no bath or shower facilities.
- Senior staff said these issues had been raised through the trust risk register, although the date these issues were placed on the risk register was September 2014, the month before our inspection.
- The date for any actions to be completed for the unit to be compliant with modern building standards as required by the Department of Health: Health Building Note 04-02 was recorded as September 2017 and May 2015 for the ventilation system.
- There were inadequate storage facilities for equipment and consumables. The storage rooms were clean and tidy, but equipment was not easily accessible due to the quantity of the equipment being stored in clinical storage rooms.
- Hoists and trolley beds were stored in the corridor.
- The hospital had the ability to temporarily increase capacity to care for critically-ill patients in a major incident, such as a pandemic flu crisis or serious public incident. The hospital was able to make up to 18 beds available for critical care. This could involve suspending other services, such as surgery and using anaesthetic rooms and the coronary care unit.
- Most patients were seen within 12 hours by a consultant. Due to the consultant rota not being fixed to meet recommendations for critical care units, there were exceptions to the 12-hour review on one third of weekends if a patient was admitted after the consultant went off duty. However, staff would present the patient to the consultant by telephone. There was no evening round on these weekends so the patient would possibly not be seen by a consultant until the following morning and, therefore, over the 12-hour recommendation.
- The lead consultant for critical care recognised this issue and told us there were expectations to have a fixed rota for consultant cover in place by April 2015.

Access and flow

- Patients were discharged from the unit in the night (between 10pm and 7am) due to bed pressures.
- We did not obtain reliable data on the numbers of patients. The data received did not match incident forms which identified three moves in one period, but the unit had identified only one.
- The unit did not collect data to demonstrate delayed discharges of greater than four hours due to lack of bed availability.
- Four hours is the comparative indicator set by the Intensive Care National Audit and Research Centre (ICNARC) to demonstrate the ability, or otherwise, to move patients out of critical care in a timely way.
- Data received demonstrated there were 79 delayed discharges from the unit from April 2014 to Sept 2014. A senior nurse told us that is was on average a nine hour delay and in some cases even days. After the inspection the trust told us that their data for the period showed an average delay of six hours
- Data was not collected on the time taken to admit a patient to the ITU once referred to them. Again we were told of delays but there lacked data to define the scale of the problem and therefore the impact on patients. This data is collected nationally in 95% of intensive therapy units and is benchmarked to review performance.

Critical care

- Some level 2 patients were cared for on the coronary care unit. There was no data easily available to support how many patients this involved and the definition of a level 2 patient on the coronary care unit appeared to be different to recognised definitions.
- The rate of patients being transferred to other hospitals due to a lack of an available bed was low with three patients being transferred in 2013/14. This was similar to other units.
- When compared to national NHS figures, there was a relatively low rate of elective operations cancelled due to a lack of an available bed in the ICU. In the period between April 2013 to September 2014, there were 10 cancellations. Half of these however, were in May 2014, when, during the first half of the month, the unit was full most days.
- When compared with similar-sized units contributing the ICNARC data, there was a relatively low rate of patients being discharged from the unit early onto wards to allow for new admissions. The impact of early discharges for patients is they might not receive the specialist care they need in a ward setting, or they might require readmission due to increased complications. In the 18 months from April 2013 to September 2014, this happened with just eight patients.
- There was an escalation policy for ICU in times of increased demand for critical care beds. The policy described the status for the unit in relation to the number of available beds. Green status was two or more available beds and red status was no available beds in ITU. The protocol had a flowchart to aid decision making and stated which staff were responsible in which circumstances.

Meeting people's individual needs

- Staff had an awareness of equality and diversity and what made each person an individual. Staff would respect different cultures and religious needs by, for example, providing only male or female staff as much as was possible if this was important to the patient. Staff we spoke with said all patients would be treated and cared for as individuals and adjustments would be made to ensure the outcomes for patients were as good as they could be.
- There were translation services available. Staff could use a telephone translation service, which we were told was available on short notice. The unit was able to arrange face to face translation with appropriate notice. Staff told us the hospital had many staff who spoke other languages and they were able to provide translation, particularly with medical subjects, if they were available at the time. Staff confirmed they would not rely upon interpretation from a child family member unless there was a serious emergency.

Learning from complaints and concerns

- Although they were infrequent, staff said they addressed and learned from complaints and concerns. Informal concerns or complaints were dealt with by staff on duty and the nurse manager either took responsibility to address these, or was informed about how they had been managed.
- The ITU had very few complaints and none in the last six months. The nurse manager said the unit would get feedback from complaints made to other departments, which might have a bearing on ITU. We saw an example of this recently where staff had been made aware of a complaint in another department about poor care.
- There was a complaints process and policy for staff to follow. The policy had been updated and was available to all staff on the trust intranet. It described the process for handling and responding to complaints.

Are critical care services well-led?

Requires improvement

All the senior staff showed commitment to their patients, their staff and their unit. However, there was not enough reliable data to base decisions upon and drive the service forward.

There was no effective programme of auditing and reliance placed upon tasks being carried out, such as safety checks, without assurances that this was the case. The governance arrangements of the unit were not providing feedback on incidents, audits, or results from those quality measures it had.

There was a lack of accountability for driving through actions and improvements. There was no audit programme or demonstration of continuous improvement plans.

Critical care

The unit produced some validated data, but the lack of participation in a national audit programme meant data was not adjusted for patient risk factors, and the unit did not benchmark itself against other similar units to judge performance.

Despite these challenges, we saw a culture of teamwork and commitment in the critical care unit. All the staff we spoke with said the strength of the unit was a friendly team who worked well together and contributed to the low staff turnover.

Vision and strategy for this service

- The senior management, senior nurses and consultants were committed to their patients, staff and unit. Nursing staff team leaders were well supported and well respected by their own teams. All staff we met were committed to high quality, compassionate and safe care and treatment. There was a vision and strategy for the service, which was described in minutes from meetings. Senior staff had an aspiration to contribute to ICNARC data in 2015, but this had not moved forward into an approved plan. The strategy was not being cohesively driven forward or promoted with the board and the future direction of the service was unclear.

Governance, risk management and quality measurement

- Audits of certain aspects of safety within the unit were not carried out and there was no audit calendar. There was no audit carried out routinely to determine if equipment checks had been regularly undertaken. As a result, the refrigerator checks being missed and some of the paediatric equipment being past the expiry date were not discovered. Another example was there being no audit of cleaning routines, so the dust in some harder to reach areas was not found. No achievements from any audits or performance indicator data were visible on the unit. Audits appeared to be done in an ad hoc manner and not following a recognised, approved or agreed programme.
- The unit did not participate in a national database for adult critical care as recommended by the Core Standards for Intensive Care Units (the 'Core Standards'). The unit did not contribute data to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland. The lead consultant told us they did not have a member of staff who was funded for this role and clinically qualified to code this information. There was motivation from senior staff on the unit to participate in this data collection, but not yet any commitment from the hospital trust to recognising and resourcing the post.
- As recommended by the Core Standards, the unit was part of a local critical care network in North West London (NWLCCN). The meetings were well attended by the members, which included 13 NHS critical care units in the local area, the local ambulance trust, and the local clinical commissioning groups. Although the unit did not participate in the ICNARC data collection, data was collected for the NWLCCN quality measures. We reviewed the minutes of the critical care delivery group meetings (an internal meeting chaired by the director of nursing on most occasions). The results of the NWLCCN were presented at some meetings, although there was no benchmarking presented against other local units.
- Staff played an active contribution on how the unit was run. There were various staff meetings on clinical and administrative matters. The critical care delivery group met quarterly and included the director of nursing at most meetings. There was an appropriate presence from other services within the hospital, although the surgical representation and attendance by physicians was described as "patchy". The critical care forum met monthly. This was an internal meeting of critical care senior staff. Serious incidents were reviewed at this meeting along with other issues, such as planning for the CQC inspection. There was no specific performance data presented to staff.

Leadership of the service

- Although the staff team were committed to their patients, the results of their work were not recognised with comparative measures. There was a lack of an effective audit driven by the leadership and the unit worked in some isolation from the directorate and the board.
- Learning from mortality and morbidity meetings was not shared with the wider directorate or fed to the board though a governance structure.
- Some of the data produced for the NWLCCN was of reasonable quality, but it did not include some important indicators about quality of care. Some of the data was not easy to understand and, therefore, could not be relied upon by the board as performance indicators.

Critical care

Culture within the service

- There was a positive culture within the staff on the unit. However, there was no evidence of a strong ability from the critical care leadership to challenge or promote the future direction of the service.
- There was a culture of teamwork. All the staff we spoke with said the strength of the unit was a friendly team who worked well together and contributed to the low staff turnover.
- Patients and relatives also commented on the positive nature of the staff they met. Comments about staff culture included, “they treat us in the way they would want to be [treated] and know what it’s like for the families,” and, “staff are professional with us and certainly with each other. Very respectful and bringing confidence.”
- The nursing staff commented on the positive support and guidance from the consultants. The specialist nurse for organ donation had a “very supportive working relationship” with the clinical lead for organ donation. Nurses we met said they were “very involved with the ward rounds” and there was “excellent team working at all levels”.
- Trainee doctors were well supported on the unit. Consultants were easy to contact when junior doctors needed advice, and were described by a trainee as “very approachable at all times”. Nurses were also supportive and helpful to junior medical staff. Trainee doctors told us the hospital had a good reputation for being “very friendly” and “a good place to work”. Teamwork was said to be “really superb” and “10/10”.

Public and staff engagement

- Patients and their relatives were asked to comment on the care provided.
- An inpatient questionnaire was in use and results were collated and presented to staff. From April to August 2014 where 10 questionnaires were returned. Charts were produced to visually display the responses. The staff shared letters they had received from patients with us, all of which had very positive comments. The hospital replied to comments to thank patients and relatives for writing to staff.
- All staff we met felt they had a voice and their opinions were valued and heard.

Innovation, improvement and sustainability

- There were no current plans in place that had been formally agreed to improve or develop the service.
- Although the risks associated with the physical environment had been put on to the trust risk register, there were no specific plans to upgrade or improve.
- The facilities on the unit for relatives and visitors were unacceptable, particularly for a service where delivering bad news is part of daily life.
- The patient notes were all on paper records. There was no plan to upgrade these to more secure, efficient electronic records.
- The team working in critical care had shared values, but there were no longer-term safety, quality or performance objectives for the team to work towards. Nurses we talked with said at their annual appraisal there were no safety goals set for the department .

Maternity and gynaecology

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

Information about the service

Hillingdon Hospital provides a range of maternity services; community midwifery services delivery antenatal and postnatal care for women, and antenatal clinics, a triage service, a day assessment service, the labour suite, antenatal and postnatal wards. Obstetric theatres are provided at the hospital. The trust has had a dedicated home birth team since 2013.

There were 4,076 registerable births in 2013 at Hillingdon hospital. Maternity services are part of the trust's women and children's health department. During our inspection, we spoke with women who used the service and members of staff, including: support workers, midwives, doctors, consultants, administrators and senior managers. In addition, we held meetings with midwives, trainee doctors, consultants and administrative staff to hear their views. We inspected the areas of the hospital where maternity services were provided, looked at care records, and reviewed information provided by the trust, such as audit and performance data. The Maternity Liaison Services Committee (MSLC) shared with us an anonymised report on the results of questionnaires completed by women using maternity services.

Summary of findings

The trust had recognised the risk to safe and responsive care because of inadequate midwifery staffing. The staffing establishment had been increased and newly appointed midwives were expected to join the trust before the end of the year. At times of high activity current risk was mitigated by the use of the escalation policy to prioritise the needs of women in labour. This meant that other areas were sometimes short staffed.

Women were able to access antenatal and postnatal services near their home and high risk women were seen at antenatal clinics at the hospital. These clinics were sometimes crowded and women had to wait for appointments. There had been no evaluation of the reconfiguration of the community midwifery service to assess its effectiveness and staff told us they were under pressure. The business case to increase staffing had been agreed; the appointments had not been made at the time of our inspection.

The wards were kept clean, but infection-control procedures were not always followed. The storage of medicines did not comply with nationally recognised good practice.

There had been improvements to the effective use of the World Health Organization (WHO) surgical safety checklist in obstetric procedures. There was a high level of awareness about the importance of safeguarding women and babies.

Maternity and gynaecology

Trainee doctors said the teaching and support from consultants was of a high standard. Midwifery staff took part in a well-established appraisal process and had opportunities for training and development. Staff were confident about the quality of care they provided, and this was reflected in the positive comments of women who used the service. Bereaved parents were well supported.

There was a systematic approach to clinical governance, which included a process for reviewing and investigating incidents, an audit programme and clear allocation of responsibility for reviewing guidelines.

Are maternity and gynaecology services safe?

Requires improvement

Suboptimal staffing levels had been highlighted as the principal risk for the service. A business case for increased staffing had been agreed and additional midwives and midwifery support workers had recently been appointed. There was evidence of appropriate escalation when there was a risk of insufficient staff numbers to provide safe care. Vacant shifts were put out to bank staff and agency, but when these were not filled there were sometimes staff shortages on the post natal ward. The midwife responsible for escalation at night also had clinical duties.

There were two never events (serious, largely preventable patient safety incidents, which should not occur) regarding retained swabs in maternity theatres. In response, the trust commissioned an audit of all theatres in February and March 2014.

Incident reporting was encouraged, although few reports were made by medical staff or trainee doctors. There was a systematic process to the investigation of incident reports and we saw evidence of action and learning from these. There had been improvements to the effective use of the World Health Organization (WHO) surgical safety checklist in obstetric procedures. There was a high level of awareness about the importance of safeguarding women and babies.

The majority of midwifery and obstetric staff had completed mandatory training. There were multidisciplinary drills to rehearse obstetric emergencies.

The wards were kept clean, but infection-control procedures were not always followed. The storage of medicines did not comply with nationally recognised good practice.

Incidents

- There had been two never events (serious, largely preventable patient safety incidents, which should not occur) regarding retained swabs in maternity theatres. In response, the trust commissioned an audit of all

theatres in February and March 2014. It included an audit undertaken by an independent experienced operating theatre nurse and an audit of policies and processes conducted by internal auditors.

- There had been 14 serious incidents requiring investigation reported in 2013/14. We saw recent communication to staff from the trust and the division to encourage incident reporting and we saw evidence of investigations of incidents leading to learning and action points. We noted that midwives also appropriately reported incidents, such as staff shortages and equipment problems.
- Incident reports were generally completed by midwives and some obstetric incident reports were very brief. We did not find trainee doctors were well informed about the process of incident reporting, or stimulated to complete them by example from consultants.
- The risk midwife coordinated the systematic response to incident reports by reviewing reports daily and escalating to senior staff immediately if appropriate. When there were concerns about clinical care the obstetric lead for risk became involved. A panel was set up to investigate serious incidents.
- An email was automatically generated to acknowledge receipt of an incident report. Midwives told us communication about follow-up had improved since the appointment of the new risk midwife, who had a presence on the wards. In addition to reporting incidents, medical and midwifery staff sometimes contacted the risk leads directly to discuss incidents.
- Information about incidents was disseminated through emails and examples highlighted in the monthly posters, which we saw in staff rooms.
- There was a monthly incident review meeting, which discussed incidents, reviewed the outcome of investigations and monitored action plans arising from investigations. The meetings were attended by senior midwives, the obstetric lead for risk and other medical staff. Other staff, including trainee doctors, were invited to attend these meetings.
- When a trend in incident reporting emerged, this was investigated. When there was a recent increase in admissions to the neonatal intensive care unit (NICU), the notes were reviewed by the obstetric and midwifery leads for risk, with input from the matron and a paediatrician. There was also a weekly meeting with children's services staff to discuss admissions to the NICU.
- Mortality reviews were held regularly following the trust mortality review process, with paediatric participation if appropriate.

Midwifery staffing

- Suboptimal staffing levels had been highlighted as the principal risk for the service. The trust had agreed to increase the establishment of midwifery staff and eight midwives had been recruited to take up post before December on the postnatal ward to reduce the ratio to one midwife to 31 women. The was using bank and agency staff to provide this level of staffing until the new members of staff started work, but had found it difficult to always fill the gaps in the rota during the summer months.
- Staff of all grades described problems with meeting demand at times. Bank and agency staff were used to meet the new staff establishment levels, but it had become difficult to find bank staff over the summer and agency staff were not always available or did not attend when booked. There had been very high activity in September, with more women admitted than usual, and the service had been on amber rating four times during the month.
- Staffing levels were below establishment on the postnatal ward on the three days of our visit and on the labour ward on the first day of our visit for both day and night shifts and we observed that the wards were very busy on some occasions. We were told that fluid output was not always recorded systematically on the postnatal ward at night because of staff shortages and this meant an assessment of fitness for discharge might be delayed.
- The use of agency staff from January 2013 to July 2014 in maternity services was above the trust average and was particularly high in the antenatal ward (16% of midwives, 11% of other staff) and the postnatal ward (11% of midwives, 23% of other staff). Agency midwives were unable to use the computer system and this had an impact on the work of the wards.
- The maternity escalation procedure was well understood by midwifery staff and was followed to mitigate risks when activity was high or the staff skills mix was insufficient. There was an allocated duty midwifery manager (pager-holder) for each shift, who undertook an assessment of staffing and activity and

acuity levels at the morning and evening handover. Out of hours and at weekend the page-holder was a midwife rostered to work clinically and this was not a separate role.

- One-to-one care during established labour was prioritised to keep women and their babies safe and had been met in 95% of cases in the first quarter of 2014/2015. At times of high activity this was achieved by moving staff, in particular from the postnatal ward. Midwives worked on rotation in the wards and felt they had the skills to transfer to other areas if needed.
- During our inspection the labour ward was full, but was unable to transfer women to the postnatal ward because there were staff shortages and delayed discharges. We observed the pager-holder taking action on the postnatal ward to check that children's services staff were reviewing babies prior to discharge. While they was there they changed the sheets of beds to free them up for women coming from the labour ward. Later, an additional midwife was moved to the postnatal ward.
- When there was a risk of unsafe care because of high activity and / or insufficient staffing, the service was put on amber alert. The ward managers, other senior midwives and specialist midwives stepped in to take on clinical duties at busy times. The homebirth service had been suspended twice in the last year when community midwives were reallocated to hospital duties at night.
- During the last 12 months, admissions to the labour ward had been suspended once. In September, the month before our inspection, there had been very high activity and the service had been on amber alert four times.
- At these times there were sometimes women in established labour in the antenatal ward and / or triage area. The risk of women giving birth on the antenatal ward had been assessed and it was agreed that one-to-one midwifery care of low-risk labouring women at times of high activity could be provided safely in one of the single rooms.
- At night, the midwife on duty at triage was also the pager-holder. When we visited triage at night, the midwife told us if there were more than two women, or any of them were in established labour or had other risk factors, they would not leave the triage area. If someone bleeped them, they sent the maternity assistant to find out more about the reason for concern. Cover was sometimes provided for the midwife from the labour ward for the bleep holder, but this was not available at busy times. This indicated that the arrangement for pager-holder out of hours was not adequate. We were told the aspiration was to have a second midwife on duty at night, who would be supernumerary, but the appointment had not been agreed formally.
- Maternity services employed scrub nurses seven days a week so that midwives did not routinely have to leave their duties to attend theatre. Staff reported that these shifts were not always filled by registered nurses so midwives had to cover this role. Midwives took the role of scrub nurse at night. This put additional pressure on the service at times of high activity.

Medical staffing

- Consultant obstetric presence was in line with national recommended practice and had recently increased overnight and at weekends to meet the national recommendation of 98 hours.
- Midwifery staff confirmed consultants were on the labour ward or resident and on call at nights and we were informed that there had been 114 hours of obstetric cover since January 2104. The consultant was not always present on the ward, and the 114 hours cover a week was not prospectively planned. The cover was also across gynaecology and obstetrics.
- There was 40-hour consultant obstetric anaesthetist cover and separate anaesthetic cover for elective caesarean sections. Out of hours, there was a consultant anaesthetist on call, who would not always have obstetric experience, which was not in line with national best practice.

Safety thermometer

- Safety thermometer audits for maternity were undertaken monthly and the results showed that there had been harm-free care on maternity wards in recent months. However, some measurements were not applicable to maternity services.

Cleanliness, infection control and hygiene

- The antenatal clinics, antenatal ward and postnatal ward were visibly clean and well ordered, individual rooms in the wards had a cleaning schedule on the doors and all were marked clean for that day. Equipment had stickers on it indicating they had been cleaned. The postnatal and antenatal ward had been

ranked first or second of the wards in the hospital in the local audits for cleanliness in each of the months in the first quarter of 2013/14. However, these audits were not using national standards.

- We found an infection hazard at the rear doors of the labour ward, which were publicly accessible. There were three infectious waste bags and one sharps box left on the floor.
- There were also blood spills evident on cupboards in the labour ward. When we pointed this out, the cupboards were immediately cleaned.
- The corridors in the labour ward were shabby, with floors cracked and worn and doors chipped. The floors in the theatre were also damaged. This meant that they could not be disinfected effectively. However, we found no evidence of incidents of infection related to this risk. Staff told us, "You do what you can to keep it clean, but it still looks old."
- Staff followed 'bare below the elbow' guidance. We observed staff using personal protection equipment, such as gloves and aprons. Hand sanitising gel was available at the entrance to, and within the clinical areas. We found that the trust processes for infection control audits were not in line with best practice as the theatres, a very high risk area, were being audited monthly instead of weekly. The rate of surgical site infections were within reasonable limits; there was one a month in the first quarter of 2014/2015 and two of these were categorised as superficial.

Environment and equipment

- The labour ward had 11 en-suite rooms, which had been refurbished to a high standard, with air conditioning and equipment available in each room.
- Cupboards on the wards were well stocked and clean.
- The adult and neonatal resuscitation equipment in the wards was regularly checked.
- Theatre staff told us equipment was regularly checked and replaced promptly when this was necessary.

Medicines

- Medicines storage did not comply with nationally-recognised standards. We observed that the clinical room on the labour ward was not locked and the fridge containing drugs in the room was not locked. Staff reported they did not know if there were any keys for the fridges, but said the room was usually locked. When we returned later, however, it was still unlocked. The trust's recent pharmacy inspection found cupboards and fridges on the labour and postnatal wards were secure, but found that drug fridge on the antenatal ward was not lockable. We were informed that the decision to have unlocked fridges had been made based on a risk assessment and the need to access drugs quickly. However, we were not satisfied that the risks had been assessed adequately.
- The temperature of the fridge holding medicines was regularly checked on the wards. However, the trust's pharmacy inspection found that the fridge temperature in the postnatal ward had been out of the agreed limits on several occasions. The pharmacy inspection also found that the temperature of the medicines fridge in theatres was not recorded regularly.

Records

- The patient records we looked at were well ordered, with no loose sheets, and notes were signed and dated. The ward clerk locked records when they left the office. We saw women with their hand-held notes and women found this worked well when they went to different appointments.
- Notes during labour indicated clearly who was responsible for care and that fresh eyes had been sought for cardiotocography (CTG) observation. The CTG traces were securely stored.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Consent was part of mandatory training for midwifery and obstetric staff, and midwifery staff confirmed they had annual training. Community midwives told us that they had good access to advice when they were thought that women might need support to make decisions, and referred women to a specialist midwife for vulnerable women if appropriate.

Safeguarding

- There was a process in place in maternity services for identifying babies at risk. All midwifery staff we spoke with had a high level of awareness of the importance of identifying risk factors and knew the specialist midwives they could discuss concerns with.
- The electronic record-keeping system flagged risk when it had been identified. There were close working relations between children's services, maternity services and social services.
- All safeguarding Midwives and community team leaders had trained in safeguarding supervision in 2013, the

trust told us further training is being planned to include ward sisters and key specialist midwives.94% of permanent staff had attended safeguarding training level 2. There was a mandatory study day for level 3 safeguarding for all midwives and obstetricians every three years, which covered a broad range of topics, including domestic violence and female genital mutilation. 70% of staff had attended level 3 training. Registrars and support workers did not have mandatory level 3 training, but were able to access the course. Trainee doctors were not all compliant with mandatory safeguarding training because they did not have safeguarding training at induction, but were assigned to training once in post.

- There were buzzers on the doors to all the wards and cameras at the entrance to the labour and antenatal wards to check people entering. We were told there would soon be a camera in the postnatal ward. However, we observed that some visitors entered the labour ward behind other visitors, without buzzing or being challenged.
- At night people coming to triage could only enter the maternity unit if the doors were opened by a member of staff. When we made an unannounced visit to the unit at night, we found we could get into the building as people came out. However, we could not enter the main hospital or the delivery suite without a member of staff opening the door. Midwifery staff told us the security service responded promptly and effectively when they were called during the day or out of hours.

Mandatory training

- The completion rate for mandatory training for midwifery staff was nearly 90% and for obstetric staff over 80%.
- There were announced and unannounced "skills drills" training to rehearse obstetric emergencies.

Assessing and responding to patient risk

- The Intrapartum Scorecard, a tool to assess staffing and activity levels on the labour suite, was completed every four hours and was a prompt to recognise the need for escalation. The data recorded on the scorecard had not yet been collated to improve understanding or activity and the pressures on the labour ward; we were told there were plans to do this.
- Midwives and trainee doctors said they felt able to discuss any concerns about the wellbeing of women with more senior medical staff. Trainee doctors were given instructions about how and where to contact consultants and said they were able to call them at weekends when there was no consultant on site. Midwifery staff said that the resident consultant at night was present on the labour ward or was readily available on call.
- We saw that the observations on the modified early obstetric warning score (MEOWS) were completed for women in the postnatal ward. Midwifery support staff explained to us the new born observations concisely and correctly. They also demonstrated a clear understanding of keeping midwives or the ward manager informed of any concerns.
- There had been a systematic audit of the use of the WHO surgical safety checklist following two never events for retained swabs. The audit used observations of the use of the checklist, including how swabs were counted and how responsibility for checks was allocated. There was also documentary analysis and validation of checks recorded on the checklist by viewing theatre registers and equipment records. The actions arising from the audit included improved instructions on swab counts and clear and documented handover of care from anaesthetists in recovery. There were also awareness-raising sessions for staff. A specific checklist for maternity had been introduced, and following feedback on its use, a revised version was being piloted at the time of our inspection, which would be relevant to all obstetric procedures.
- Theatre staff told us the use of the WHO surgical safety checklist had improved and there was now an awareness of each team member's responsibilities. Compliance had increase and recent audits indicated this was now 100% for elective caesarean sections and over 90% for emergency sections. Pre and post-list briefings did not take place. We were told multidisciplinary team debriefs took place in the days following a difficult delivery.

Major incident awareness and training

- The maternity escalation and divert procedure prompted a systematic response when there were problems meeting demand. The procedure adhered to the NHS Pan-London Maternity Divert Policy to ensure that the London Ambulance Service and neighbouring maternity units were informed when the unit was on amber or red status. There was a trigger list to assist the allocated duty midwifery manager with decision making

about unsafe care in relation to skills mix or inability to deliver fundamental care. They informed the head of midwifery, assistant director of operations and clinical site practitioner of a decision to go to amber status in hours and the hospital duty manager out of hours.
- The decision to move to red alert and suspend the service was to be made in liaison with the head of midwifery and the supervisor of midwives out of hours. Out of hours, the decision to suspend the service was ratified with the executive on call. The escalation policy also addressed unsafe care in the community midwifery service.

Are maternity and gynaecology services effective?

Good

There was a systematic approach to reviewing guidelines and identifying action to improve practice. An audit programme had been developed and was regularly reviewed. Actions to improve practice were identified and implemented. Outcomes for women and their babies were within expected limits.

Women had a named community midwife for antenatal and postnatal care in community settings, in addition to antenatal appointments at the hospital when appropriate. However, community midwives had higher than recommended caseloads and this affected the responsiveness of the service provided. Midwives had access to specialist midwives and obstetricians for advice and there were clear pathways for high-risk women, for example those who were diabetic or who were overweight.

There was good multidisciplinary working, in the labour ward for high risk women. However, the care for women and babies on the postnatal ward in the immediate post-labour period was not always in line with best practice because of midwifery staff shortages.

Midwifery staff had annual appraisals and access to training. Trainee doctors were well supported.

Evidence-based care and treatment

- We viewed service guidelines on the intranet and found there was a wide selection of topics covered and that they were evidenced based and current. Trainee doctors were made aware of them on induction. Responsibility for reviewing guidelines was assigned to one relevant professional and was overseen by the governance midwife. Liaison with paediatric services was identified when relevant.
- All guidelines were accessible on the intranet by staff in substantive trust posts. Agency and locum staff did not have access to the intranet but we were told that where needed guidelines and policies would be printed and placed in mothers' notes.
- There was a regular report to the governance committee listing the principal guidance for maternity services with an assessment on the effectiveness of the current implementation plan. Actions were identified to improve good practice, for example, a business plan for the appointment of a new perinatal mental health service.
- There were clear lines of accountability for the audit programme, which was set for the year by the multidisciplinary maternity governance group. The programme included annual audits, such as induction of labour, regular audits specified by the trust such as the WHO surgical safety checklist and audits in response to specific issues arising from serious incidents or complaints. Completed audits and actions arising from them were reported at the governance group meeting and monitored by the governance midwife. The latest report to the governance group described the actions completed on the recommendations from the re-audit of the trust policy on 'Safeguarding Children / Vulnerable Women in Maternity' such as a review of notes to check on improvements to documentations, the development and use of postnatal communication sheets and the appointment of an additional part-time midwife for vulnerable women. Action points were cascaded to teams and there was a regular half-day education sessions at which audit results were discussed.
- 81% of women were booked before 13 weeks in the first quarter of 2014/15, below the target of 90%. When late referrals were excluded, the figure was 97%. Nearly all women were recorded as having a named midwife at booking.
- Assessment of risk took place at the first antenatal booking. Midwives worked with the sonographer in screening and provided support to women and there

was multidisciplinary team discussion of high-risk women. The service took part in the neonatal screening audit and performed close the national average for 2012 for maternity indicators.

- A Maternity Triage Care Bundle had been developed and piloted by doctors and midwives at the trust to promote consistency of care provided for women presenting with shortness of breath, vaginal bleeding, headache, abdominal pain, raised blood pressure or reduced fetal movements. A re-audit of the outcomes following implementation demonstrated that women were managed more consistently in triage and there was a reduction in the number of unnecessary admissions.
- We noted that there had been a complaint about delays and confusion about responsibility for women who presented at triage with symptoms unrelated to pregnancy. The head of midwifery told us that, where possible, these patients would be admitted to a maternity bed and obstetricians would liaise with the relevant medical specialty. However, staff with nursing experience were not always on duty to care for these women.
- There was guidance available on the management of women with medical needs unrelated to pregnancy and compliance with this had been audited."
- There was no access to interventional radiology at the trust in an emergency. High risk women were referred to a tertiary centre, but there were no formal arrangements to transfer women who required this service unexpectedly. This risk was recognised by the division and the trust and there was an action plan in place.
- The service was introducing the UNICEF UK Baby Friendly Initiative, which was promoted by the World Health Organization to promote good care for new born babies. Midwives were recording skin-to-skin contact between babies and their mother immediately after birth and this had reduced the number of babies with low temperatures who needed intervention from paediatric staff. However, we observed that the shortage of midwifery staff on the postnatal ward affected how much support they were able to give. Some women said that they wanted more support with breastfeeding. This might have an impact on how confident women felt about breastfeeding and looking after their babies.

Pain relief

- The full range of pain relief was available on the labour ward to meet the individual needs and preferences of women during labour. These included epidural analgesia, opiates and nitrous oxide (gas and air), paracetemol and the use of water, in a birthing pool.
- We saw several comments from women about delays in getting pain relief on triage, and we were told that pain relief on the postnatal ward was not always promptly available.

Nutrition and hydration

- 83% of women were breastfeeding their babies when they were discharged, better than the national average, but worse than the London average.

Patient outcomes

- The service's outcomes were close to the national average for puerperal sepsis, maternal readmissions, and neonatal readmissions.
- Emergency caesarean section rate for 2013/14 was 17% compared to a national rate of 15%, and had fallen to 16% in the first quarter of 2013/14. The elective rate had risen in the first quarter and the overall rate for this period was 27%, the same rate as the previous year and slightly worse than the national average of 25%.
- 54% of deliveries were normal, meeting the service target.

Competent staff

- A midwife and a trainee doctor who had recently started working at the trust described the induction as the best they had attended in the NHS.
- The preceptorship programme for newly qualified midwives was receiving attention in order to prepare for newly-appointed midwives. Newly qualified midwives rotated to the different areas of the hospital and the community.
- The training database highlighted when training was due. Midwives, support workers, theatre staff and administrative staff told us their training was up to date. Training and was delivered by workshop, e-learning and on the floor. During our inspection, there was multidisciplinary training in interpreting cardiotocograms when monitoring the baby's heart rate.
- There had been an increased emphasis on completing mandatory training and if a member of staff was asked to work instead of training, they were expected to complete an incident report.

- A common comment from women responding to questionnaires was that the midwives they saw, in the community and at the hospital, were knowledgeable.
- All midwifery staff we spoke with said they had an annual appraisal at which additional training and development were identified. 86% of midwifery staff had an appraisal in 2013.
- The national staff survey results found Hillingdon Hospital in the best 20% of trusts in the country for staff reporting they had a well-structured appraisal in last 12 months.
- A member of staff who had previously been a support worker told us they had been encouraged to train as a registered midwife. Other midwifery staff said they had had the opportunity to identify development opportunities at their appraisal. A new born hearing screener said her team was understaffed and they was not released to attend open days in London for screeners.
- We saw a list demonstrating that all midwives had an allocated supervisor of midwives (SOM). The ratio of SOM to staff was 1:20, worse than the recommended ratio of 1:15. The Local Supervisory Authority annual audit report of April 2014 found that staff were aware of how to contact their SOM, but made recommendations for improvements, including reducing the ratio.
- Trainee doctors told us they were well supported, with supervision, regular teaching and opportunities for training. One of them told their time at Hillingdon Hospital had been the best as a doctor and they had decided to specialise in obstetrics as a result of his experience. Consultant cover was good, and there was a clear focus on supervision of trainees. The results of the GMC survey of trainee doctors confirmed that trainee doctors were positive about the support they received in maternity services.

Multidisciplinary working

- Staff of all grades told us there was good team working and everyone's contribution was respected. Midwives said consultants and other medical staff valued their knowledge. We observed respectful interaction between staff. A consultant commented, "we're all pulling in the same direction."
- There were separate handovers between shifts for different professional groups. We found there was no consistent pattern for handover between medical staff on labour ward, and the consultant handover was not always at the same time as the trainee doctor handover.
- Paediatricians did not take part in handover. We were told there was effective working with children's services staff, who were informed when they should attend a birth and responded rapidly when needed in an emergency.
- The community midwifery teams worked with other health professionals in the community to support mothers and their babies.

Are maternity and gynaecology services caring?

Good

Women we spoke with and who responded to surveys were positive about the kind and caring staff. They said they were involved in making decisions about the birth. Bereaved parents were well supported.

Compassionate care

- We observed midwifery and medical staff speaking to women with kindness and respect in all the areas we visited.
- The response rate to the NHS Friends and Family Test in maternity services had been low, but was increasing. Responses were generally positive and close to the national averages.
- Women who took part in the CQC's Maternity Services Survey 2013, which summarised women's experiences, were positive about their experience of the maternity service, in line with the national averages.
- Women we spoke with during our inspection were very positive about the kindness of the staff. Very few women rated the service as poor in the questionnaires distributed in in the children's centres by the Hillingdon Parents Maternity Forum. Women referred to midwives in their comments as "friendly" and "kind".
- There were many positive comments about the staff on the labour ward with 28 of the 48 women responding to the questionnaires indicating the service was excellent.

- Women were less positive about their experience of the postnatal ward, although they praised the kindness of the staff.

Patient understanding and involvement

- Women said that midwives were focused on their needs. They said community midwives were informative and told them who to contact if they had concerns. Women who saw consultants at antenatal appointments praised the care they received and said doctors explained the risks of pregnancy in a straightforward way.
- The service scored above average in the national CQC's Maternity Services Survey 2013 in response to the question: 'During your labour, were you able to move around and choose the position that made you most comfortable?' Women told us that the midwives were respectful of their choices, including the use of pain relief.

Emotional support

- We found that careful thought had been given to ways of supporting bereaved parents. A team of midwives specialised in bereavement support for mothers, and there was training for other staff. When women lost a preterm baby, bereavement midwives talked to the families about sensitive disposal of the remains. There were memory boxes which were offered to parents who had lost a baby.

Are maternity and gynaecology services responsive?

Requires improvement

Women were encouraged to make a choice about how their pregnancy and birth was managed.

The community midwifery service provided local women with continuity of care and supported women following the birth with services provided in the local children's centre. There were specialist midwives and doctors to provide care for women who were vulnerable or who had high-risk pregnancies.

The antenatal clinic for women with medical needs was crowded, and women sometimes had to wait to see a doctor. The triage area did not provide privacy. Postnatal wards were sometimes short staffed and it was difficult to provide a responsive service that met individual needs.

Service planning and delivery to meet the needs of local people

- There were stresses on the community midwifery service, which indicated that the planning for the service was unsatisfactory. In addition, there had been no evaluation of the reconfigured service or the home birth service to find out whether it was meeting its aims.
- A business case for increasing staffing levels, had been agreed by the trust. The appointment of new midwives at the maternity unit meant that there would be sufficient staff to provide a responsive service.
- The community midwifery practices had been reconfigured in 2013 and were now based at children's centres, with a view to increasing efficiency, and promoting multidisciplinary work based on the women and their babies. However, we found the midwives under pressure, with some managing high caseloads of 200 or more. The trust had agreed in principle to the case for increasing the number of community midwives, but no formal action had been taken.
- In addition, there were concerns in the community midwifery teams about newly qualified midwives, who worked for a four month period as part of their first year rotation, finding the level of responsibility challenging. Because the team leaders worked clinically, there was limited support for these midwives and there was a view that four months was not sufficient to put their learning into practice.
- We found there was an understanding of the needs of the local population. The service had set up meetings with the Afghani and Somali communities to improve understanding of the way women could access maternity services.

Access and flow

- Women in the local area were able self-refer to the service by telephone or by completing a form on the website. Referrals were also made by GPs and other health professionals.
- The community midwifery service provided most antenatal and postnatal support to women at children's centres. Antenatal and parenting classes were also held at the centres, and there were plans for more support with breastfeeding to be available to women, in accordance with the UNICEF UK Baby Friendly Initiative.

Maternity and gynaecology

- A dedicated home birth team had been set up in September 2013. There were currently four midwives on the team and the number of home births was increasing, and was currently meeting the target of 4% of births.
- Women were given a named midwife after the first booking appointment with the community midwifery service. The staff we spoke with told us appointments were often running late because midwives found the15 minutes allocated were not sufficient for some women. Feedback from women was generally positive about the service, but indicated that continuity of care was not always provided. Some women also said the postnatal appointments at the children's centres were not always well organised and they sometimes had to go to different centres for appointments.
- The service provided consultant led care for women needing increased medical and obstetric surveillance in pregnancy and childbirth. Community midwives we spoke with said the referral routes worked well when they needed to refer to specialist midwives or clinics. They said they could contact an obstetrician for advice and refer women to the day unit. Women reported that they often saw the same consultant throughout their pregnancies.
- We observed that the facilities for the hospital antenatal clinics and triage were not promoting a responsive service. There were plans to expand the space for antenatal clinics and triage when maternity services were reconfigured in 2015
- There was not always enough seats for women and their partners attending the morning antenatal clinics. When the reception desk was unattended, a long queue developed. Some women complained about the long waits.
- The triage service screened women for access to inpatient services. Women telephoned triage and were advised whether to attend and the ambulance service brought pregnant women directly to triage. Waiting times were variable, and some women said they had received a prompt service, which had provided them with the reassurance they needed. Other women complained when they had to wait to see the midwife and then the doctor. This resulted in delays in receiving pain relief. We observed that there was a lack of confidentiality in triage. Women had complained that the doctors' and midwives' telephone conversations could be overheard.
- There were appointments at the day centre attached to the antenatal ward for assessments by midwives and medical staff. Women we spoke with there said they were seen promptly.
- There were two dedicated theatres located next to the labour ward and there was a dedicated theatre team including scrub nurses during the day. Out of hours emergencies would be staffed from the main theatres and midwives covered the scrub nurse role. In emergencies, women were sometimes transferred to main theatres, which was accessed by a covered walkway. Blood was not available by cell salvage in maternity theatres. There was no dedicated high dependency unit and women requiring high-level care following surgery were taken to the main intensive care unit, which meant they received appropriate care, but were separated from their babies.
- Women attending the termination of pregnancy service were treated in the gynaecology ward, or in the labour ward if in the later stages of pregnancy, in line with good practice, and were given a choice when this was appropriate.

Meeting people's individual needs

- There was no dedicated room allocated for bereaved mothers and their family. There were plans to make one of the rooms on the labour ward the centre for bereavement care, although this would be used as a delivery room at times of high activity. Bereaved parents had previously donated a cooling cot so that parents were able to spend longer with their baby.
- Women were encouraged to make a choice about how their pregnancy and birth was managed. There was no birth centre, but a midwifery-led care pathway had been introduced and 38% of women were cared for solely by midwives. The dedicated home birth team introduced in September 2013 as part of the community midwifery service offered increased choice for women and in the year to date had been provided to nearly 4% of women. This was expected to increase, but Midwives told us that they did not have the capacity to provide a home birthing service to all those that want it. Interpreting services were booked for antenatal appointments by the community midwifery service when they had information from the GP that this was needed. Interpreters were also booked for antenatal clinic appointments if needed. Staff told us they also used the telephone interpreting service.

- There were specialist midwives for vulnerable women, safeguarding, as well as for patients with HIV and other infectious diseases.
- Women were generally positive about the responsiveness of the staff on the postnatal ward, but midwifery staff said it was difficult to respond promptly when the ward was short staffed. Staff said they allocated tasks and worked as a team to make sure the women to address these difficulties.
- In response to requests from women and their families, the service supported partners to stay out of hours. Partners agreed to follow specific instructions when they stayed overnight.
- We found the early pregnancy advisory unit (EPAU) responsive to women's needs. The number of scanning slots for women had been increased to reduce the waiting time for fetal abnormalities. Women in early stages of pregnancy , namely miscarriages less than 12 weeks were offered day surgery in designated slots daily on the emergency list. The service worked closely with the gynaecology ward to ensure women were well looked after. Staff were concerned that the planned relocation of some maternity services would result in the gynaecology ward no longer being co-located with the EPAU. However, the Head of Midwifery and Women's Care told us after the inspection that the EPAU will remain col-located with the gynaecology ward.

Learning from complaints and concerns

- Complaints about maternity services were coordinated by the assistant to the head of midwifery, who allocated the complaint to the appropriate manager to investigate and tracked response times. The response times to complaints were within target.
- Meetings were often arranged by the head of midwifery, to be held with the chief executive and the complainant so that they could provide a verbal explanation as well as a written response to the complaint. This included an apology when the service had failed to provide the expected service.

Are maternity and gynaecology services well-led?

Requires improvement

There had been no evaluation of the 2013 changes to the community midwifery services. Some staff felt they were not listened to or involved in the changes made to the service.

The business case made to the board for increased staffing had been successful. The service had identified other areas for improvement and developed business cases, which had been put to the board. However, there was an absence of contingency plans to mitigate the impact of the shortcomings on current service provision.

There was an effective governance structure, led by the head of midwifery. There were assigned obstetric leads for clinical governance roles, however, it was not clear who had overall obstetric responsibility for clinical governance.

There had been effective planning for the refurbishment of the labour ward and the service had continued during the work.

Vision and strategy for this service

- The business case made to the board for increased staffing within the hospitals maternity unit had been successful and would enable maternity services to manage risk and improve care and responsiveness at the maternity unit. The case had been made to increase community midwifery services staffing and to strengthen the home birth service. There were plans to relocate the triage service and to build a birth centre when maternity services were reconfigured as part of the commissioning strategy for West London for 2014/15. We were given information about an audit of referral pathways, which would inform these plans and improve women's pathways. However, there were no contingency plans in place to manage the poor facilities for hospital antenatal clinics and triage.
- The refurbishment of the labour ward had been achieved with minimal disruption to the service through careful planning, risk assessment and the engagement of staff.

Maternity and gynaecology

Governance, risk management and quality measurement

- Risks associated to recent never events had been effectively managed and mitigated but local risks associated with the management of medicines and frequency of infection control audits had not been and there was little service specific patient harm data collated by the division.
- The head of midwifery chaired the maternity services governance meeting and oversaw an integrated clinical governance process. However, it was not clear who had overall obstetric responsibility for clinical governance.
- We found that maternity services had processes in place to promote evidenced based care and to audit adherence with guidelines.
- Maternity services used a dashboard to monitor the safety and responsiveness of the service. Parameters for this were either established service key performance indicators or were set by the service leads.
- There was a systematic response to incident reports and complaints. However, the incidents recorded on the dashboard did not correspond with those on the incident reporting system. Junior doctors were not engaged in reporting incidents.
- The termination of pregnancy service was compliant with requirements relating to access to this service.

Culture within the service

- Newly-appointed midwives and trainee doctors said they felt the trust induction engendered a positive attitude that continued in maternity services, where they had felt welcome and well supported. Junior doctors and student nurses training at the trust came back to work there.
- Staff on the labour ward were generally positive about their work, team and senior management commitment in the 2013 staff survey. There were also higher than average responses to these aspects of their work from staff on the antenatal and postnatal wards.
- The community midwifery service and antenatal clinics were negative about many aspects of their work and this was reflected in our conversations with staff. While it was recognised that staff found the changes to the community midwifery services disruptive and this affected their response, staff felt their views were not listened to and they were not involved in plans for the service.

Leadership of the service

- There were good working relations between the divisional manager and senior clinical staff. A consultant said, “You can knock on her door any time.”
- The head of midwifery demonstrated an understanding of maternity services and the challenges they faced and had put the case to address those challenges.
- Midwifery staff told us they were supported by their ward managers.

Public and staff engagement

- Midwifery and administrative staff understood the trust focus on the values of CARES, a programme to improve patient and staff experience and to increase patient and staff engagement.
- Staff we spoke with were proud of their work and this was reflected in the staff survey from all areas of maternity services.
- The Maternity Liaison Services Committee (MSLC) was active and attended by senior midwives. A representative from the CCG recently joining the meetings. The MLSC shared information they collected about women’s views of the service, but the Healthwatch representative on the committee told us the service did not share information, such as the maternity dashboard at meetings. However, the head of midwifery told us the dashboard was available at these meetings.

Services for children and young people

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

Information about the service

The service for children and young people is comprised of an inpatient ward with 12 cubicles (two of which are en-suite and can be used as isolation rooms), a family room and an eight bed ward. About 3000 children a year are admitted to this unit.

The paediatric day-care unit sees 5000 children a year for day surgery, scans, blood tests and clinical reviews. An adjoining children's outpatient clinic holds consultant and nurse-led clinics for diabetes, neurology, allergies, respiratory and endocrine illness and babies. Clinics requiring special equipment, such as ear, nose and throat (ENT), dental and eye clinics are held in the main outpatients department alongside adult clinics. A children's hearing service for detecting and treating hearing impairment is based in a separate building.

A children's (paediatric) oncology shared care unit (POSCU) works with two tertiary centres, Great Ormond Street Hospital and University College Hospital London.

The neonatal unit has a maximum capacity of 18 cots. Five intensive, three high-dependency cots and 12 special care cots. Facilities for parents include a parents' kitchen, sitting room and two bedrooms. This unit is part of the North West London Neonatal Operational Delivery Network. It is located in the maternity building at the opposite end of the hospital from the children's ward.

We spoke with 14 children and families and 30 staff, including consultants, doctors and nurses as well as catering, porters and administrative staff. We observed care and looked at the care records of patients. We reviewed other documentation including performance information provided by the trust.

Services for children and young people

Summary of findings

We found staff were dedicated, caring and compassionate and responded to children's needs. The staff worked well as a supportive team, learned from incidents and strove for effective patient care in sometimes difficult circumstances with insufficient staff and equipment, particularly on the children's ward.

Although a number of issues had been identified as risks, action to reduce the level of risk had not been a demonstrable priority for management. This meant that there was a failure to mitigate known risks and as well as the inherent risks to children, this also led to evident frustration amongst staff.

Outcomes for patients were generally good and treatment was in line with national guidelines and there were clear strengths in specialist areas in treating both neonates and children. However, there was no overarching vision of where the service hoped to be in the years ahead. There was a limited approach to involving either staff at all levels or those who used the services for children and young people, or staff at all levels in planning for change.

Are services for children and young people safe?

Inadequate

Staff on the children's wards and the neonatal unit were very supportive of each other and worked hard to provide safe care. However, we had a number of concerns about safety, security and cleanliness, mainly in relation to the children's wards.

There were insufficient permanent nurses, and bank or agency staff were employed on every shift in the inpatient ward. Staffing did not meet the recommendation of the 2013 Royal College of Nursing, even for a general ward, although we saw that plans were in hand for a phased increase to reach this standard by April 2015 and a recruitment campaign was in place.

The staffing levels on the neonatal unit were adequate and staff did not report any shortages of equipment.

There were regularly a significant proportion of children with high dependencies being cared for. Nurses therefore, were often working under undue pressure, and circumstances in which errors were more likely to be made.

We also had concerns about the condition and security of the premises, and observed lapses in good hygiene practice on the part of staff and visitors.

Nurses on the paediatric ward reported shortages of basic items of equipment, and there was a limited air supply of piped-air for children requiring ventilation. Staff on the neonatal unit did not report any shortages of equipment.

Doctors were covering this in the interim without nurse involvement. There were weaknesses in the system for ensuring all actions discussed at the weekly 'safety net' meeting were followed-up appropriately and recorded. We were told of imminent plans to improve this through better recording and more staff resource, but the risks to children through not having appropriate systems to safeguard them were not mitigated.

Incidents

- The risk registers indicated managers were aware of the main risks to safety. However, some significant risks had been on the risk register for a year or more.

- The spread of reported incidents across the paediatric units was illustrated by the figures for March and April 2014. There were 56 in the neonatal unit, 20 on the inpatient ward, eight on the day ward and five in outpatients. We saw staff had made changes to practice in response to serious incidents, to ensure they were not repeated. An example of learning from an incident had been to ensure consultant supervision at clinics. Outpatient clinics would therefore, be cancelled when a consultant was away.
- Nurses told us they were often pressured to admit children from the emergency department (ED) when they considered they could not provide wholly safe care. These occasions were not being reported on the incident-reporting system, a normal route to escalate concerns.
- Doctors and senior nurses had reviewed serious potentially avoidable paediatric incidents (so-called never events) which had occurred in other hospitals in England in order to learn and improve safety in the department.

Cleanliness, infection control and hygiene

- The wards were well supplied with antibacterial hand gel and barrier-nursing equipment. However, we observed six occasions in a short period (on 3 October) when neither doctors, nor nurses, cleaned their hands when they moved between patients.
- The importance of visitors cleaning their hands to improve infection control was not emphasised. We saw no parents using hand sanitising gel on entering either ward.
- The children's wards appeared broadly, clean. However, the cleaning audits had no clear system for ensuring that dirty areas identified in an audit were subsequently cleaned. Some cleaning audits did not highlight the necessary actions at all.
- We saw good practice in the in the neonatal department, where clinically clean items were stored, individually covered in a large storeroom. Nurses on the paediatric wards did not use dated 'clinically clean' stickers for nurse-cleaned items.
- On the neonatal unit, we observed staff washing their hands regularly. However, because of the unusual ward design, there was sometimes a business need to walk through the intensive care area. On one occasion, we saw a person delivering linen who walked through four sets of doors without washing their hands.
- The outpatient areas appeared to be clean.

Environment and equipment

- There were a number of security risks. Although entry to the children's wards was through a locked door with a surveillance camera and intercom, we saw staff admitting people with no conversation, or visual check on the screen. Once inside the area, the inpatient ward was accessible through push doors without swipe card access, and the doors to the day ward were open at both ends, giving access to the rest of the hospital.
- At night, we found some external doors in the corridor leading to the children's ward were unlocked and one door did not close at all because it was faulty. As the children's ward was quite isolated from the main hospital this was a security risk. We did not see any security guards patrolling this area of the hospital.
- The trust had an abduction policy, but we were concerned that a child could just walk out of the ward unseen if there was no one at the nurses' station.
- The doors open to the garden during the day had no surveillance camera. The garden itself is overseen by a camera on an adjacent building.
- Immediately outside the inpatient ward, a very steep set of stairs led to a doctor's training room. There had once been a child gate to restrict access. When we raised this issue during our visit, a temporary gate was installed.
- Staff on the children's wards reported shortages of equipment, both equipment for high-dependency patients, and routine items such as probes to test oxygen levels in body, and ear thermometers. Shortage of materials was high on the list of concerns of staff in the paediatric staff survey, and we saw staff searching for, and not finding, items during our visit.
- The ward had limited facilities for children needing support with breathing. Some children, after stabilisation in the ED, were transferred to the theatre, which had dedicated paediatric ventilation equipment, where a child could await transfer to a specialist hospital.
- However, other children needing support with breathing were taken to the inpatient ward, where a portable ventilator was available. Access to ventilation was limited on the ward due to the capacity of the air system. This was high on the local risk register.
- Staff told us that over bed reading lights in the children's ward did not always work, and was shortly to be replaced.

- The clinical room door on the day-care ward was wedged open, and had no lock or handle. Door handles in the entire area were at standard height, rather than mounted high as is usual in children's areas in hospitals.
- The large resuscitation trolley on the inpatient ward had equipment piled on top of it: a sharps bin, disposable gloves, suction catheters. While comprehensively stocked, it would be difficult to wheel out this trolley in an emergency and to find the right equipment quickly. The resuscitation guideline on the trolley was out of date as it was due for review in January 2013.
- The equipment was not well organised. There were blood bottles in both the airway and breathing trays. We were told the rest of the trust had new resuscitation trolleys, but the paediatric department had not yet agreed the content of their trolleys.
- The ward also had a portable paediatric bag, kept alongside the resuscitation trolley, with pouches of emergency equipment suitable for treating patients of different weights. This was used when children were taken to theatre and was also for use, if needed, in outpatient clinics.
- A second resuscitation trolley on the children's day care ward had only been checked intermittently, two to three times a month since June 2014. Endotracheal tubes had been reported as two months out of date, but staff said the hospital resuscitation team had advised the ward to keep these "as a reminder" because the tubes were out of stock. When we asked the resuscitation team about this, they admitted it would not be safe to use out-of-date tubes.
- The outpatient clinics adjoining the day-care clinic were light and bright and had good play equipment, as did the children's hearing centre.
- The outpatient clinics did not have their own child-appropriate resuscitation equipment. We were told equipment would need to be brought in from the children's ward.

Medicines

- Medication was stored correctly and regular checks were done and recorded. Fridge temperatures were not checked daily, contrary to recommended practice. Staff said they relied on the alarm to indicate a rise in fridge temperature.
- Medication errors had been a recurring theme in both wards and outpatients. The inpatient ward had 45 medication incidents over the past year, the highest number of all wards in the hospital. The neonatal unit had 19 medication incidents. We saw evidence of learning from mistakes, but nurses told us that the cause of many of these incidents was pressure of work because of staff shortages even if this was not always recorded on Datix. The paediatric wards had a named pharmacist as a contact, but the hospital did not employ a paediatric pharmacist. There was limited pharmacy support at weekends, so nurses had to check their stocks of commonly-used medicines before a weekend or bank holiday.
- Cytotoxic drugs, for oncology patients, were kept securely in the nurses' room alongside the notes for those patients.

Records

- On the neonatal unit, we saw examples of incomplete patient notes and student signatures, which had not been countersigned.
- Patient notes on the inpatient ward were not all complete. Timings of admissions from the ED were not recorded, several sets of notes required papers to be filed and we saw notes with no folders which had come from A&E for patients admitted out of hours. We were told the documentation for these would be completed next day.
- Preoperative checklists for children were fully completed.
- There was a good record system for diabetic patients presenting to A&E which alerted the on call diabetic team.
- Most patient records were stored off site. We were told there had been problems initially with case-note retrieval, but this had improved recently. Staff said they aimed to amalgamate temporary notes with main notes within 36 hours. However, several staff told us they could not be sure all correspondence relating to a child would invariably be added to their individual folder.
- Regularly used notes, such as those of oncology patients, were locked in the staffroom.
- We looked at two audits of records for children who did not attend outpatient appointments for whom there was a safeguarding concern. This had revealed weaknesses in record keeping and information sharing. Results from the most recent audit had been less good than those in the previous audit. We saw an action plan but no ongoing log of progress, nor any system of spot checks to raise standards of record keeping.

Services for children and young people

Consent

- Staff obtained consent appropriately. Staff told us that children were involved in discussions about their treatment and we saw, in patient notes, that older children had signed their consent to procedures, alongside their parents' consent, in line with good practice.
- We saw signed consent forms on the notes of children having surgery. A parent told us that the proposed procedure and possible complications had been explained before they gave consent.

Safeguarding

Most nursing staff had level 1 and 2 safeguarding training – not all had level 3 training, but we saw training dates for the current year had been arranged.

- Doctors and nurses reviewed the notes of potential safeguarding cases at a weekly 'safety net' meeting. Handwritten notes of these were recorded in book. Evidence of all necessary follow-up action being taken was sporadic, a few actions had signatures against them, but many were blank. We were told notes would soon be kept electronically and checks would be introduced to ensure follow up of each action.
- We looked at the notes for seven weeks of meetings that happened in the three months prior to our inspection. In all the meeting notes we looked at except one date, there were some cases that did not appear to have been followed up, and there were as many as five actions not followed-up in two sets of meeting notes.
- The data sharing between the hospital and urgent care centre was not appropriate due to there not being an interface between computer systems. This issue was regularly mentioned in weekly safeguarding meetings because of the risk of missing child protection concerns relating to frequent attenders. The significant risk had been on the risk register since February 2014, without resolution.
- Additional administrative support had been agreed to support information sharing, but was not yet in place.
- Doctors were supported in safeguarding issues through a regional peer network. There were no regular safeguarding supervision arrangements for other staff.

Mandatory training

- We saw a training matrix that flagged when nurses' training was due. Permanent staff were mainly up to date, but some of the 16 bank staff working in paediatrics needed updates.

Assessing and responding to patient risk

- Child and Adolescent Mental Health Services (CAMHS) were not available out of working hours or at weekends. Relevant children presenting to the ED out of hours had to be admitted to the children's ward and looked after by an agency-registered mental health nurse until an assessment could be arranged.
- Staff used a paediatric pain assessment chart, and, for older children, paediatric-controlled analgesia was available. There was no children's pain team.
- The Paediatric Early Warning Score (PEWS) had been introduced in the spring. We saw examples where staff had not escalated elevated results in younger children.
- A standard transfer list was being developed for seriously ill children presenting to A&E and stabilised before transfer on to the ward or to theatre. Twelve children, on average, were transferred each month. We were told that specialist children's strategic clinical network groups were being formed to look at paediatric intensive care. However, a solution providing safe care for children transferring internally or externally was needed at the time of the inspection.

Nursing staffing

- Only 7% of paediatric staff in the 2013 staff survey had thought there were sufficient staff.
- Staffing on the ward was below Royal College of Nursing (RCN) guidelines. We were told the trust aimed to meet these guidelines by April 2015. The rotas showed a 1:6 nursing ratio, although this had recently increased to 1:5 for winter pressures. Recommended staffing levels for children under two should be 1:3 and for children over two, 1:4. At night, there was no band 6 nurse, so the most experienced band 5 nurse on the rota was placed in charge. This role was not supernumerary. The night-time staffing arrangements did not meet the requirement for senior nurse cover for 24 hours as per Royal College of Nursing (RCN) standards, 2013.
- The ward did not have funded beds for high-dependency unit (HDU) patients, but regularly admitted children, usually from the ED, with high dependencies. There had been 20 such children in January 2014 and 15 in March.

- One evening, we saw five qualified staff on the ward for 15 children, six of whom were aged under two, and we observed and saw on handover sheets that others had high dependencies.
- Additional children were continuing to arrive on the ward from the ED. We were told the staff development nurse for paediatrics was measuring six hourly dependencies against staffing, in an effort to clarify staffing needs and we saw staff did their best to mitigate the risks by good team work, and sometimes helping out across wards. However, improved staffing ratios were clearly needed to ensure safe care.
- Only two specialist nurses in the whole paediatric team had Advanced Paediatric Life Support (APLS) training. The recommended standard is for one nurse per shift in each clinical area (ward / department) to be trained in APLS as per RCN standards, 2013.
- At the start of September there were 10 vacancies on the paediatric wards and 4 on the neonatal unit. In addition to nurse vacancies in the ED for which the paediatric department supplied staff. Nurses thought turnover was because of lack of opportunity to progress; eight nurses had recently left the children's ward, nurses on the neonatal unit left to go to bigger units.
- The one or two bank or agency staff on every shift could not carry out the full range of nursing tasks. We saw from the rota that, occasionally, agency staff did not even have paediatric training. This put additional pressure on the permanent staff, particularly at night.
- The neonatal unit was not staffed for all cots to be full. Since the start of the year, occupancy in intensive care had been 55%, although 75% in the special care baby unit (SCBU). If there was more than one ventilated baby in intensive care or there was other high acuity then bank staff had to be obtained. We were told care was often 1:2 not 1:1. The SCBU staff ratio was 1:4, which met national guidelines, and the unit had sufficient staff for the dependencies of babies during our visit.
- Following the publication of the 2013 Royal College of Nursing guidance on staffing, the senior management team undertook a review of the nursing establishment across the service.

Medical staffing

- There were eleven consultants working across the paediatric area, each with several lead responsibilities. When on call, the consultants covered both paediatrics and neonates. A consultant was in the hospital until 10pm every weekday night and another consultant was also on call at that time. Junior doctors said consultants came to the hospital when out of hours, if needed.
- The department did not keep a central log of junior doctors with an APLS qualification. Registrars had APLS training, so the hospital met the recommended standard of having a doctor with this training on any one shift, in theory as per RCN standards, 2013. However, because the standard was not met for nurses and because of the distance between the different units of the paediatric department this was a risk. This risk was higher at night when a senior house officer and a registrar sometimes covered the inpatient ward, neonatal unit and ED.
- Nurses on the children's ward said they rarely saw a registrar at night, even with new ward admissions and quite sick children.
- Junior doctors reported they had good training and support.
- Locums were used regularly to cover vacant shifts. We were told induction of locums sometimes brief and they often did not have password access to computers.
- The doctors on the neonatal unit had effective links with the postnatal ward and had oversight of babies on that ward.

Are services for children and young people effective?

Good

The services for babies, children and young people used evidence-based guidance from national organisations in providing care. The team audited their performance against national guidelines and protocols for most common conditions were up to date. Care was multidisciplinary and involved community and social services as appropriate.

Evidence-based care and treatment

- Guidelines, based on national guidelines, were on the trust's intranet. Sometimes these had been adapted for this hospital. The bronchiolitis guidelines were restricted to 24-hour treatment because of the limited capacity for continuous positive airway pressure or ventilator breathing support on the paediatric ward.

- The paediatric department had been auditing its practice against national guidelines over the last two years and updating its protocols. Although we saw a few guidelines that had passed their review date by several months. The February 2011 croup guideline had been due for review in January 2014, most were up to date however.
- The neonatal unit had clear criteria for admission, and subsidiary criteria for possible admission. We saw good practice, in retinopathy of prematurity (ROP) screening to prevent severe sight impairment, jaundice monitoring and early treatment pathways, and encouragement of the use of breast milk to avoid bowel problems in young babies. The unit had also reduced admissions to special care due to low baby temperature through promoting skin-to-skin contact with the mother on the postnatal ward.
- In September this year, a Paediatric Early Warning Score (PEWS) had been introduced for babies who needed monitoring in the postnatal unit. It was too early to assess results, as this was a new process. There were effective links between the neonatal unit and the postnatal ward.
- The strengths of the paediatric wards were in diabetes care, in respiratory and allergy programmes and in cancer treatment.

Pain relief

- We did not see a paediatric pain policy, and there was no paediatric pain team. We saw examples of a pain tool for use with children, but this was not present in every child's nursing notes.
- A pain guideline was available on the neonatal unit.

Nutrition and hydration

- The trust had developed an attractive laminated children's menu with a colourful design, but we did not see this menu being shown to children. A staff member wrote their menu choices on a white sheet of paper. Whereas the child menu contained a note about meals for special diets or ethnic and religious choices, the standard ward sheet did not mention these, so it was possible some children might not be aware of the options.
- Sandwich spreads, fruit and drinks were available for children throughout the day, and snack boxes were available for children who had missed a meal.
- Catering staff worked with nursing staff in relation to special diets and we saw evidence of training on food safety and infection control.

Patient outcomes

- We noted that readmissions to the inpatient ward were 5% within seven days and 10% within 28 days. These figures included the readmission of cancer patients, who tended to return more frequently. We did not see figures excluding these children to be able to benchmark with other departments.
- The neonatal unit (NNU) had many babies that transferred to specialist units for treatment and then returned to Hillingdon Hospital for the next stage of their care so there was a steady flow of babies in and out of the unit.
- The trust performance in national audits of paediatric asthma and diabetes was in line with national averages. The diabetes service offered 24-hour support and had introduced clinics in schools where there were clusters of pupils with diabetes. The long-term aim was to improve diabetes control in an age group where compliance was at risk. While it was still too early to see the full impact on diabetes control, the clinics had improved attendance and were appreciated by teenagers.
- The hospital was a designated paediatric oncology shared care unit (POSCU) level 1 for children from Hillingdon, Ealing and West Middlesex. It provided shared cancer care for 30 children. The unit had sufficient nursing staff, including cover staff and two oncology consultants. The paediatric department were aiming for a level 2 designation to be able to give infusions through central venous lines. It would need more beds for this and we were told additional accommodation was being identified.

Competent staff

- A range of study days were held as well as specialist courses such as introduction to cytotoxic medication, continuing care in childhood cancer nursing, diabetes and mentorship in practice. A notable gap was mental health training.
- Doctors had weekly simulation training, but nurses said they rarely had time to take part in this training.
- Doctors commented that nurses had good clinical judgement, were caring and knew when to escalate concerns.

- Handover was supervised by the most senior clinician and written handover sheets were used. We observed that handovers were managed very effectively.
- The trust values: communication, attitude, responsibility, equity and safety, were used in performance development meetings as a way of embedding these in staff behaviour. 92% of staff had had annual appraisals of their performance.
- The department did not use link nurses to promote initiatives or cascade information, and had no safeguarding link or infection-control nurses.

Multidisciplinary working

- Patient's notes included input from other members of the multidisciplinary team, such as physiotherapists where relevant. Although the hospital did not employ paediatric physiotherapists, staff told us an adult physiotherapist could be called out of hours if needed.
- The junior staff in the neonatal unit said they were not involved in the weekly MDT meetings. One person told us this meeting lacked a regular coordinator.
- There were good transition arrangements for older children with long-term conditions moving into adult services, such as diabetic and respiratory patients and those with epilepsy. Cancer patients, if diagnosed under 16 years of age, stayed under the care of the Hillingdon unit, whereas older young people used the Teenage and Young Adult Service for cancer treatment at University College Hospital.
- The role of the play therapist role appeared underutilised on the ward. The staff member appeared to provide general support on the ward rather than actively supporting children to master anxieties or prepare for hospital procedures. The post holder was not invited to contribute to clinical judgements through play-based observations.

Seven-day services

- The hospital was in the early stages of seven-day working. Some services, such as pharmacy, physiotherapy, and occupational therapy were on call out of hours.
- There were consultant ward rounds at weekends on the wards.

Are services for children and young people caring?

Good

Babies, children and young people and their families were treated with compassion and kindness. Parents and relatives generally spoke highly of the care given in the children's wards and outpatient clinics. We saw examples of where staff went the extra mile for patients

We saw older children being involved in decisions about their care and we saw nurses explaining what they were doing to younger children.

Compassionate care

- It was clear from written comments, observations and talking to parents, that staff were seen as friendly, attentive and caring.
- The NHS Friends and Family Test was not mandatory for paediatrics. For the months it had been completed, families were generally very positive in their comments. The test was not used with people attending paediatric outpatient clinics.
- Children had named nurses who would be their nurse if they were on the ward again.
- We spoke to two children who were frequent inpatients who liked the staff and felt "at home" there. A cancer patient who came regularly to the day care ward said they'd got to know the cancer nurses well and that "they were really helpful and kind".

Patient understanding and involvement

- A parent reported clear and good communication from doctors and nurses over a long-term patient with a priority card for the ED. This parent, and another we spoke with both felt involved in decision-making in relation to their child. However, another parent with a baby on the neonatal unit reported inconsistency in the approach of different doctors and nurses, and in their willingness to involve parents.
- Two young people said nurses explained what they were doing and offered choices.

Emotional support

- There were psychology services for children, including for those with long-term conditions, such as diabetes.
- A parent praised a student nurse who had stayed an hour and a half beyond her shift to support parents whose son was being ventilated on the children's ward.

Services for children and young people

- There was some bereavement support to parents of babies who died. Parents could come back to the hospital for viewing and to take pictures and make up memory boxes. The hospital offered an hour a week of psychological support to parents with babies on the neonatal unit, which we considered a low level of support.
- We were told families with a child with cancer were well supported and we saw evidence of this in 'thank you' cards and in speaking to parents.

Are services for children and young people responsive?

Requires improvement

Children and young people's services generally met their needs and those of their families, though greater use could be made of translated information for families for whom English was not their first language.

There were sometimes delays in the system for young patients being admitted to the ward from the emergency department (ED), waiting for medicines on discharge and delays in sending out discharge letters to GPs. We also saw a patient for surgery being called too early and having an unnecessary wait in the anaesthetic room.

Parents with children attending outpatient appointments did not usually wait long for diagnosis and treatment.

The unit had no outreach support for babies and their parents who had been discharged from the neonatal unit, although, they had strong links to the seven day community paediatric nursing team.

Parents told us they had the information they needed about their children's conditions and about treatment.

Families in the main, had not had concerns, but said they knew how to give feedback if they wanted to.

Service planning and delivery to meet the needs of local people

- We saw leaflets about medical conditions available in some other languages, but nurses seemed uncertain of what translations were available, which meant relevant information was not always offered. The main languages in Hillingdon in 2011 were: Punjabi, Polish, Tamil, Urdu, Somali and Arabic. Some information about childhood illnesses was in five languages, others in seven or eight languages.
- We were told interpreters could be arranged in advance to attend clinic appointments. The trust told us that interpreters were arranged in advance either face to face or via the telephone, and that all the paediatric consulting rooms had two telephones to enable instant interpretation and to facilitate the flow of the conversation between the parent and interpreter. On the neonatal we were told there is a confidential speaker phone for interpreted consultations or conversations.
- There were meals to appeal to different cultural groups, although we could not be assured that children were routinely made aware of these options.
- A service had recently been set up for local GPs to enable them to email specialities in paediatrics for advice. GPs had welcomed this, although it was too recent to see if it had any effect on reducing admissions.

Access and flow

- The flow of patients from ED to the ward was sometimes slow, even though the ward was not always full. This was, in part, because of delays in getting beds ready. This led to some young people having unnecessarily long waits in the ED after the decision to admit.
- Only about a third of discharge letters were completed in 24 hours across both wards, well below the target 85%. There were particularly long delays for surgical patients because surgeons needed to be available to complete forms. Letters were sent by post if the patient had already been discharged.
- Parents mentioned discharge was sometimes delayed because of waiting for medicines to take home.
- The paediatric ward was a long way from theatre and children had to be transported, or walk, for over ten minutes. Because of the distance, theatre staff sometimes called patients too early. We saw an example of a child waiting half an hour in the anaesthetic room, which increased the stress of the experience.
- Nursing staff considered that the management focus on a snapshot of bed occupancy at midnight was less meaningful on a children's ward than for adult wards. As there was only one children's ward, patient flow had more impact on workload than midnight occupancy. The policy was to discharge children to minimise

overnight stays as far as possible. In addition some children came to the ward for short term observation because the environment was more suitable than A&E. This meant that, unlike adult wards, several children might occupy a bed in a day.
- There were sometimes problems in setting up outpatient follow-up for discharged patients, however, the waiting times for children actually attending clinics were not long, and parents were kept informed about any delays.

Meeting people's individual needs

- The neonatal unit had two rooms where parents of babies could stay just before taking their baby home. If necessary, an additional room could be found on another floor.
- A chair bed at each bedside in the inpatient ward enabled a parent to stay overnight, and there was a bathroom, a parents' room and a kitchen parents could use. Another room within the children's unit had a bed for use in an emergency. If a child was admitted in transit from Heathrow Airport and the family had nowhere else to stay.
- A children's playroom and a large garden play area provided staff with plenty of entertainment options for the children.
- Children in hospital for more than five days were referred to the pupil-support team from the local authority for a tuition service
- The ward operated open access for 17 children with cystic fibrosis and six children with Primary Ciliary Dyskinesia (a lung disease) who had shared care with the Royal Brompton Hospital. There was also rapid access for children with cancer. Following a phone call a bed would be allocated and the patient could be treated within an hour of admission.
- Regular coffee mornings were held for parents with babies on the neonatal unit, or who had been discharged. This provided support to parents. Parents were also offered information about the buddy scheme run by Bliss, a charity supporting care for premature and sick babies.
- The options for supporting sick babies in the community include referral to the seven day community paediatric nurse team who met the parents and baby on the neonatal unit and then supported the babies in the community with direct contact with the baby's consultant. The babies have rapid access arranged with the relevant information held in the children ward and in A&E. Home visits are undertaken by the consultant paediatrician if required. If the baby has a life limiting illness or requires significant symptom control the family are referred to the Great Ormond Street Hospital's symptom control team and the local hospice.
- The hospital had no outreach service to provide ongoing care and support for babies discharged from the neonatal unit. Referrals were made to the health visitor, or to the paediatric community team if babies needed oxygen. The unit had strong links to the seven day community paediatric nursing team.
- The paediatric outpatient area adjoining the children's wards was child friendly. However, children were required to attend adult outpatient areas for clinics such as fractures, ENT and dental surgery. The latter areas provided toys within the limitations of the space available, but were less child friendly.
- Text reminders were sent to parents/carers for outpatient appointments, which staff told us had improved attendance rates.
- The experience of patients with mental health problems was poor for those admitted out of hours.

Learning from complaints and concerns

- There were few formal, written complaints about paediatric services. Parents mentioned the "tired" environment of the ward, concern about security and one person complained about long waiting time for appointments for blood tests. Action was being taken to improve these waiting times by employing two phlebotomists.
- Parents mentioned problems in booking outpatient appointments. Staff were aware of errors in booking appointments and had set up an audit to explore where the errors were occurring. In part, it appeared to result from time pressures on nurses.

Are services for children and young people well-led?

Requires improvement 

The paediatric services were part of the womens and children's division, led by a clinical director, who reported to the joint medical directors. An assistant director of operations reported to the chief operating officer. There

were separate managers for the children's ward, children's day care and outpatients, the neonatal unit and the paediatric ED. These managers reported in to two children's nursing service managers.

There did not seem to be an overarching vision for children's services. Change was mainly initiated by specific individuals in their own specialist areas.

Most of the concerns we identified were known to senior managers. There seemed to be a lack of urgency in addressing these issues.

The culture was not centred on the needs of children in all areas. There were numerous small examples of decisions made for the convenience of staff.

Vision and strategy for this service

- We did not see a clear vision for the service as a whole. Although staff were committed to providing good quality care, our sense was of a service working hard to cope with day-to-day issues, rather than to improve continually. Safety issues, particularly nursing ratios, were not demonstrably seen as top priority by management. However, we saw a phased plan to comply with Royal College of Nursing guidelines 2013 by April 2015.
- Future service development was based on 'Shaping a Healthier Future' principles of moving towards seven day cover of senior decision making. In addition there was a plan to increase specialist oncology provision.
- A number of staff felt that children's services were not a top priority for management.

Governance, risk management and quality measurement

- The trust board did not have a champion for children's services to drive improvement.
- Children with high dependency were admitted to a children's ward because of a lack of HDU beds. The ward was not adequately staffed for even less dependent children. This issue (along with other known risks) had been on the risk register for a year.
- Doctors had put in a lot of work over the past year to update guidelines and ensure good practice in treatment. The division participated in national clinical audits and those required for other bodies, such as commissioners.
- Staff on the ward did not have a good understanding of the role of senior managers in using safety, quality, activity and financial information to help develop service goals. Nurses did not feel their concerns were reaching senior management, so communication did not seem to be working from ward to board, or vice versa.
- Key points from the paediatric clinical governance meetings were cascaded to staff in a quality and safety newsletter, but this did not reach all nursing staff.
- Although we could trace the recording of risk through from local to corporate risk registers, this escalation didn't demonstrate that it was a driver for change.

Leadership of service

- Children's services were part of the womens and children's division. Some nurses were unaware of the management structure beyond their unit. Both nurses and doctors told us senior management, including the medical director and board members were not very visible to staff.
- At ward level, nurses told us they were frustrated that their concerns about workload and equipment did not appear to be escalated effectively when they reported these up through the matron. We noted that the senior nurse / bed manager on site did not visit the children's ward at night.

Culture within the service

- It was clear from the staff survey that staff felt too many conflicting demands and were not able to give the care they aspired to. Nurses said they had to work fast, and had little emotional support from managers. They did not feel valued.
- Staff were not routinely reporting incidents such as inappropriate admissions as they did not see any response from leadership to address known issues.
- The culture was not centred on the needs of children in all areas. There were numerous small examples of decisions made for the convenience of staff, for example, staff not wanting locks on the ward's swing doors (which might improve patient security) because nurses had to use the doors so often to get equipment from the other ward.
- There were tensions between the paediatric ED and the inpatient ward, which meant ED and the ward did not operate as a seamless service. Newly appointed paediatric nurses in ED would rotate through the ward. This might over time improve understanding between the two areas.

Services for children and young people

Public and staff engagement

- Staff had taken account of feedback from surveys arranged by others, for example the paediatric oncology survey and the diabetic peer review, but the views of families and children were not actively sought to influence the design and running of services. The NHS Friends and Family Test was not being used consistently to assess the quality of the service.
- Nurses felt engaged with their patients and wanted to provide a good service to children and their families, but many were overwhelmed by the workload, and felt unsupported when they raised concerns about children's safety. They felt they were not able to contribute to service improvement.
- The frequent use of email to inform staff about change did not appear sufficient to embed change. More face-to-face communication was needed and might raise morale.

Innovation, improvement and sustainability

- Staff generally believed there had been some gradual improvements made in recent years, but capacity and resources was an ever-present issue, and might compromise the sustainability of good intentions
- Clinicians had some plans for the development of specific specialist services, for example, aiming to deliver level 2 child cancer services. However, these rested on fragile foundations while nursing staff felt they were 'fire-fighting' and had no time to plan for the future.
- Individual specialities within the wider service, such as the diabetic service and the allergy clinics had developed some innovative ideas.
- An innovative paediatric diabetes team had been shortlisted for HSJ Safety Awards and Quality In Care Awards for reducing DNAs in outpatients by providing clinics in secondary schools.

End of life care

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

Information about the service

The Palliative Care Department, based at The Hillingdon Hospital, comprises of a Hospital and Community Specialist Palliative Care Team and provides a service that covers the trust on the Hillingdon site and the Hillingdon Community. The Hospital Specialist Palliative Care Team (SPCT) includes one whole time equivalent (WTE) consultant post, two WTE Palliative Care Clinical Nurse Specialists (CNS) posts and a 0.6 WTE Clinical Psychologist post. In addition, the Lung Cancer CNS and the Upper Gastrointestinal CNS see their patients from referral right through to the palliative phase when they are in the acute hospital setting and work closely with the SPCT. Patients on the Mount Vernon site can be referred for assessment by consultant but there is no CNS cover for the Mount Vernon site.

The trust reported 686 patient deaths from April 2013 to March 2014. The number of patient deaths in the first three months of this financial year was 167. The SPCT had a caseload of 664 patients during April 2013 to March 2014.

We visited medical and surgical wards, including care of the elderly wards, and considered the care given to patients at the end of their lives in specialist areas such as the emergency department, Critical Care Unit and Intensive Therapy Unit. We spoke with six patients, four relatives and over 20 staff of all disciplines. We looked at 22 sets of patient medical and point of care records. We met the chaplains and the mortuary staff and were shown the resources and facilities they had available to them..

Summary of findings

The SPCT hoped that the newly established committee and the recent appointment of a board director lead would increase the visibility of end of life care (EOLC) in the hospital. They said this would ensure that appropriate and consistent EOLC was provided to patients by all staff across the hospital and not be seen as the sole responsibility of the SPCT.

The SPCT talked passionately about future aspirations to bring patient's EOLC to the forefront of staff minds and to develop integrated care pathways that involved community services such as nursing, palliative care, GPs, ambulance, hospices and care homes, to frail and older patients, and those dying through complex health issues. It was hoped that this would decrease the number of unnecessary admissions to the hospital.

We saw that there were regular ward and SPCT MDT meetings to discuss patients who had been recognised as dying. The trust had developed, but not implemented end of life guidance to replace the Liverpool Care Pathway. The completion of 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms was variable and the documentation of mental capacity assessments was inconsistent.

All the staff involved in end of life care were passionate, caring and maintained patients' dignity throughout their care. Relatives told us they were supported and felt informed at all times. One relative described the care as "outstanding".

End of life care

The SPCT did not have the resources to provide support to patients seven days a week, however there was an out of hours on-call system. Hospital staff reported they felt able to request support from the SPCT whenever it was required. The SPCT usually responded within 24 hours. 60% of the patients supported by the SPCT were non-cancer patients. This showed a good balance between cancer and non-cancer patients being provided with the specialist services from the palliative care team.

There were no dedicated palliative care beds at the hospital and it was not always possible to care for people at the end of their life in a side room. There were very few rooms in the hospital for private conversations to be held. The SPCT were able to arrange rapid discharge for people who wished to die in a different location. They also had access to dedicated palliative care beds in a local nursing home.

There was no trust EOLC policy or strategy. There is a Hillingdon Borough wide End of Life strategy for 2013 to 2016 and action plan that is monitored at the borough End of Life Forum which the trust is a member of.

Staff reported there had been very little senior management engagement until the very recent appointment of a board director. There were limited governance systems although some audits had taken place. Action plans had been developed but there was no evidence of changes being implemented. We did find some examples of good leadership, especially within the SPCT. Ward based staff were committed to providing high quality care for patients at the end of life.

Are end of life care services safe?

Requires Improvement

The trust had developed, but not embedded, end of life guidance to replace the Liverpool Care Pathway. Guidance developed by the Specialist palliative care team (SPCT) was available on the trust website and there were plans to reissue a pocket size guide for junior medical staff. The completion of 'Do not attempt cardio pulmonary resuscitation' (DNACPR) forms was variable and the documentation of mental capacity assessments was inconsistent.

Patients told us their pain was well controlled and anticipatory medication was prescribed and available when needed. End of life care (EOLC) was not included in the trust mandatory training programme. The SPCT had an increasing workload but staffing levels to meet demand have not been reviewed. The trust had suspended the appointment and training of end of life link nurses on the wards to support the delivery of quality care. Staff recognition of a dying patient and the support they required varied across the wards. This was dependent on staff with an interest in EOLC or senior staff providing support and on the ward guidance to more junior or less experienced staff.

Incidents

- There were no never events or serious incidents relating to this core service reported.
- All staff spoken with were knowledgeable about incident reporting processes.
- The SPCT reported five incidents since May 2014. The incidents included no plan of care for a patient at the end of their life and patients being discharged without anticipatory medication.
- Some ward staff told us that there can be delays in transferring patients home due to waiting for medication from pharmacy. A member of staff told us they were aware of an incident where palliative medication had not been sent with a patient going home.
- Mortuary staff were aware of the incident reporting system and gave examples of action taken following an incident.

End of life care

- SPCT received information highlighting the learning from the investigation and improvements to care following serious incidents through memos and a staff newsletter.

Medicines

- Patients reported they received adequate pain relief.
- Syringe drivers, used to administer regular continuous analgesia, had been standardised in response to a national patient safety alert.
- Records showed that patients at risk of deteriorating and who may need additional medication to alleviate their symptoms had medicines prescribed in advance, so that patient waiting time and discomfort was minimised.
- Electronic prescribing was not currently available in the trust; however, minutes from the Clinical Governance and Risk committee in April 2014 noted the plan to roll out e-prescribing for chemotherapy regimens.
- We were told there were no nurse prescribers in the SPCT. The team discussed the patients' needs with the specialist palliative care consultant and medical teams across the hospital who would prescribe the appropriate symptom control medication. The SPCT confirmed patients returning to their home were provided with a supply of their medication and a list of the medication prescribed. There were systems in place to ensure patients using a syringe driver to administer analgesia were sent home with the equipment.

Records

- Generic risk assessments were completed for all patients as there were no specific care plans for end of life care.
- The trust had stopped using the Liverpool Care Pathway.
- The trust had recently developed the 'THH Individual Care Plan for Patients in the Last Hours of Days of Life' stickers to be placed in patients notes as an aid for nursing and medical staff. This included the trust care of the dying checklist and prompted staff to review and revise care plans to ensure patients' comfort needs were met and that they communicated with and involved patients and relatives in decisions. The stickers had not been implemented at the time of inspection.
- End of life guidance developed by the SPCT was available on the trust website and the clinical lead told us there were plans to reissue a pocket size guide for junior medical staff.
- DNARCPR care plans for children were completed in conjunction with the paediatric palliative care team from Great Ormond Street Hospital. These care plans were reviewed at the point of the child's admission and updated. Two DNACPR forms were in use at the trust. An updated version (triggered by a change in legislation in June 2014) had been introduced in August 2014 and was being piloted on the wards. The trust was proposing to carry out monthly snap shot audits of the new forms.
- We saw eight completed DNACPR forms. The majority were completed by middle grade doctors and countersigned by a consultant. There was some evidence that the reasons for the decision were documented as were the discussions with relatives/ carers but this was variable.
- Following our inspection the trust informed us that the old stock of DNACPR forms had been removed from all clinical areas at Hillingdon and Mount Vernon Hospitals and they had been replaced with revised forms which included the additional line regarding completion of the mental capacity form. When we returned on our unannounced inspection, we found the new forms had been completed for patients who had been admitted since our announced inspection.
- The completion of forms was variable. Some forms were completed fully and in detail, while other forms had gaps specifically when it came to discussions with families or advocates and multi-disciplinary best interest decisions. In one case it was unclear as to who had overseen the decision and reviewed the DNACPR form as this section had not been completed appropriately.
- We attended the handover meeting on one ward where staff had discussions as to who had a DNACPR in place. We then asked staff on the ward which patients had a DNACPR in place. Staff reported an additional patient to whom had been listed in the handover meeting. When we looked at this patients file we were unable to find the DNACPR form in their notes. We asked staff what they would do if they believed a patient had a DNACPR directive but in actual fact did not or there was no paper work to support this. They told us it would be a clinical decision as to whether to attempt resuscitation.
- We asked staff to locate the missing form for the patient they believed had a DNACPR in place. This was not

found while we were on the ward, but had been located when we returned to the ward a short while later. They told us it was in the file but had been hard to find as it was not located in the front of the file.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The DNACPR documents required the completing doctor to assess the person's mental capacity. The assessing doctor was required to tick yes for patients who had capacity to discuss and make a decision about their resuscitation status or no for patients assessed not to have the capacity. The doctor was also required to record the results of the assessment and discussion with the patient and their family, friends or advocate in the patient notes and on the DNACPR form. Out of the eight DNACPR forms seen, two assessing doctors had ticked the Mental Capacity Act (MCA) questions indicating the patient did not have the capacity to discuss or make a decision relating to resuscitation, and they had not documented the details of the capacity assessment either in the notes or on the form.
- We raised concerns with the trust senior managers after our announced inspection about the poor documentation and understanding of the MCA across the trust. In response the trust added an additional sentence to the DNACPR form stating 'If the patient lacks capacity the mental capacity form must be completed and placed in the patient's medical notes.'
- We looked at a further ten DNACPR forms on three wards during our subsequent unannounced inspection. We noted three patients had been found not to have capacity to make decisions relating to their resuscitation status. We did not find the mental capacity form that must be completed within the nursing notes. We asked a member of staff where we could find the form and they were unaware of what the form looked like or where it would be filed. They told us the new form had been in place for about two months however the trust action plan suggests it had been implemented following our announced inspection.
- The DNACPR form allowed for the decision to be reviewed if the person's condition changed or improved.
- The trust has conducted an annual audit of the completion of the DNACPR documentation since 2009. Data provided by the trust showed that the 100% completion benchmarks were not achieved in nine of the 10 target areas. The resuscitation committee noted the results 'were not that great' particularly around documenting reasons for decisions and communicating / discussion with the person or relatives when patients lacked capacity. There was also a reduced compliance with consultants completing or verifying the decision / form.
- The MCA audit (staff understanding) was carried out two yearly. The most recent result reported in April 2014 and presented to the July 2014 Quality and Risk Committee showed 55% of staff were aware of their responsibilities under the act. This was reported as an increase of 18% on the 2012 audit result of 37%.
- Minutes showed the safeguarding lead had raised the provision and uptake of level 2 MCA training with trust Quality and Risk Committee to make it mandatory for clinical staff.
- Processes were in place to apply for Deprivation of Liberty Safeguards (DoLS) where there was an identified issue. This is to ensure that people in care homes, hospitals and supported living are looked after in a way that does not inappropriately restrict their freedom. We were told less than five applications were made in the last 12 months – none of which were granted. Applications were made mainly on behalf of patients in elderly care wards or were dementia related.
- The trust has access to an Independent Mental Capacity Advocate (IMCA) and a senior nurse could request their help. There was no system in place to monitor referrals to the IMCA.
- There were policies and procedures available on the trust intranet including guidance was available for staff on advanced planning and welfare attorneys. Staff told us they had access to the information and were able to contact the SPCT and safeguarding lead if they had any queries.
- Staff told us that best interest meetings were held when a patient lacked capacity and these involved the clinicians involved in the patients care, relatives or carers and an independent advocate if needed.
- The trust is a member of the London Cancer Alliance and attended network meetings.

Safeguarding

- The SPCT staff were aware of the trust Safeguarding lead and demonstrated they knew the process to raise safeguarding concerns appropriately and in accordance with trust procedures.

End of life care

- The Safeguarding vulnerable adult policy was available to staff on the intranet. Version 3 was issued in June 2014 and ratified by the Safeguarding Committee.
- The revised 'Working Together to Safeguard Children' March 2013 guidance emphasises that effective safeguarding systems should be in place when professionals who come into contact with children and families are alert to their needs and to any risk of harm that individual abusers or potential abusers may pose to children.
- The training matrix showed the SPCT were not required to complete training in safeguarding children at any level. Although the team does not support children in palliative care they were providing care and support to patients with children, which meant they may require an awareness in safeguarding children in order to identify any signs of abuse.

Mandatory training

- The SPCT had not achieved the trust's benchmark of 80% compliance in mandatory training for 2013/14. The team had achieved an average of 73%. The core subjects staff had not achieved the required standard are listed below.

Fire Safety Awareness

57%

Blood and blood products

27%

Basic life support level 3

50%

Conflict resolution

71%

Conflict resolution refresher

50%

Moving and handling level 2

55%

Local induction

0%

- The team had achieved the required standard in all other mandatory training which included: health and safety, basic life support level 1, and infection prevention and control.
- Training in end of life care did not currently form part of the trust's mandatory training programme.

Assessing and responding to patient risk

- We found a mixed response from nursing staff across the wards in understanding how to identify a patient was dying and what support to offer.
- The recognition of and response to a patient dying varied across the hospital and relied on either nursing staff having a personal interest in EOLC or more experience senior staff supporting junior members.
- Where the support from the SPCT was sought patients were quickly assessed and appropriate support advice was given to ward staff.
- The specialist palliative care team responded to requests to see patients within 24 hours. Data provided showed 92% of patients referred were seen within the timescale and the remaining 8% were seen within 48 hours.
- Patients were deemed to be in the end phase of life by the senior nurse on the ward and doctor involved in the patients care.
- Staff reported they could call the SPCT and they would see the patient within 24 hours or sooner if needed. Patient records corroborated this. Patients with lung or upper gastrointestinal diseases were also supported by clinical nurse specialists already involved in their care into the palliative phase.
- The SPCT held weekly meetings to discuss new patients referred to the service and this was attended by the chaplain.
- Patients receiving EOLC overseen by the SPCT had clear evidence of the discussions and involvement with everyone involved in their care. Patient's records whose care was not overseen by SPCT were not always as detailed or comprehensive.

Nursing staffing

- The SPCT had three clinical nurse specialists covering two whole time equivalent (WTE) funded posts. One WTE post covered the acute trust and one covered the community.
- The trust had suspended the appointment and training of end of life link nurses on the wards.

End of life care

Medical staffing

- SPCT medical staff comprised three part-time consultants covering two full-time funded posts.
- The team had no junior doctors attached to them at the time of inspection but they do have on occasion, and they are supported to develop skills and expertise in end of life care.
- The SPCT medical staff provided on-call consultant cover at night and weekends.
- The consultants worked across primary and secondary care to provide integrated care to palliative care patients.

Extended team

- Oncology support and advice was available form staff running the Macmillan Information Centre in the hospital. Support and advice was also available from the acute oncology consultants and CNS.The team were supported by a part-time psychologist.
- The SPCT were supported by three administration staff.

Major incident awareness and training

- In the event of an increase in demand for refrigerated mortuary space the trust had a large multi person capacity fridge to store up to 31 bodies.

Are end of life care services effective?

Requires Improvement

The palliative care team were available on site during working hours and a consultant on call provided out of hours support. The palliative care team were following best practice guidance and provided advice to staff. Nursing staff on the wards provided good care with limited knowledge and pathway tools to assist them.

Patients reported receiving adequate pain relief and anticipatory prescribing of pain relief was standard practice.

There was limited monitoring of patient outcomes in relation to end of life care taking place across the trust. An action plan to address low scoring areas of the National Care of the Dying Audit Hospitals audit (published in May 2014) had been written in September 2014. There was no evidence that any changes had been implemented.

Evidence-based care and treatment

- The management of the clinically deteriorating / acutely ill patient policy was referenced to NICE guidance (NICE CG50 2007).
- The trust's 'Policy & guidance for the provision of care and respect in death' had recently been made available on the trust's intranet. It was for all staff who were involved with the care of the dying, the deceased and the bereaved. This document was ratified in August 2014 but we found that it was not referenced to NICE guidance. The SPCT consultant was aware of the policy but reported to have had no involvement in its creation and was unaware that it had been made available to staff. The SPCN was not aware of the document.
- The trust had taken action in response to the 2013 review of the Liverpool Care Pathway and removed it from use. However, the trust had not embedded an end of life care pathway.
- The SPCT have developed local end of life guidance which included the use of guidance stickers.to act as an aide memoir for staff. These were to be used as a guide for clinical staff to ensure appropriate individualised care is planned and delivered. We were told that the sticker system was being introduced, but it was not being used at the time of our inspection.
- There was evidence the team monitored where patients with lung cancer died, however, this did not identify whether this was the patients choice.
- An integrated strategy for 2013-16 had been developed by Hillingdon End of Life Forum which the SPCT were a member of. The strategy was developed to address the six step care pathway set out in the Department of Health's End of Life Care Strategy 2008.
- Care guidelines had been developed to reflect the six step care pathway.
- The trust participated in the National Care of the Dying Audit Hospitals (NCDAH). The report published in May 2014 showed the trust scored on a par with the England average in three out of seven of the organisational national targets and slightly better than the England average for one national target.
- There was evidence that the trust had taken action to address some of the national targets not achieved. For example a dedicated board member had been appointed to the trust's EOLC steering committee.
- We heard the SPCT were to attend the November 2014 senior nurse meeting to discuss plans for end of life care and training.

End of life care

- The trust achieved better than the England average for four out of ten clinical key performance indicators in the NCDAH. They achieved the England average in one clinical national targets and the remaining were worse than the average.

Pain relief

- Patients reported their pain relief was adequately managed and anticipatory medication was available.
- Syringe drivers were used to deliver regular, continuous analgesia.
- The trust had a pain scoring tool as part of NEWS documentation.
- The trust scored 80% which was better than the England average of 51% in the NCDAH for prescribing medication for the five key symptoms (pain, agitation, nausea, noisy breathing and dyspnoes) that may develop during the dying phase.

Nutrition and hydration

- Patients were risk assessed for signs of malnutrition and the Malnutrition Universal Screening Tool (MUST) was used.
- Patient's wishes in respect of eating and drinking were discussed at time of the EOLC decision and staff were required to develop individualised care plans as a result of these discussions.
- We looked at 22 patient records and saw the majority had completed assessments. We observed one patient who was receiving end of life care whose MUST assessment stated there was no risk identified and they had no special dietary requirements despite having gastric cancer. The patient told us about their difficulties with eating and drinking and therefore the assessment and care plan did not accurately reflect the patient's needs.
- The trust NCDAH score was worse than the England average for review of the patient's nutritional requirements at 39% to the England average of 41%.
- The trust NCDAH score was worse than the England average for review of the patient's hydration requirements at 48% to the England average of 50%.
- We were told by one set of relatives whose family member had recently died at the hospital that they had received appropriate nutrition and hydration during the last stages of their life.

Patient outcomes

- An action plan was agreed in September 2014 in response to the NCDAH. All the areas of concern had been identified and specific staff were responsible for reviewing, planning, costing and presenting each action within a specific time frame, of which most were to be completed or reported back on by December 2014. The trust told us that the SPCT participated in the Specialist Palliative Care Bereavement Survey (FAMCARE 2) in July 2014 and results were awaiting the results.
- The National Gold Standards Framework (GSF) is a training programme which enables generalist frontline staff to provide a gold standard of care for people nearing the end of life. The SPCT reported they had worked with care providers in the community to achieve the gold standards framework. However the SPCT told us most of the staff working in local care providers, such as care homes, were happy with the community palliative care nurses supporting them rather than completing the GSF training.
- In the NCDAH the trust scored 67% for reviewing interventions during patient's dying phase, this was better than the England average of 56%. However they were 9% worse than the England average of 82% for reviewing the number of assessments undertaken in the patient's last 24 hours of life.
- The trust scored 18% in the NCDAH for reviewing care of the body of the deceased and providing a relative or friend written information following death, this was much worse than the England average of 59%.

Competent staff

- The trust's training matrix data indicated that there were six nursing staff that had last been appraised between July 2012 to August 2013. One of the three administrative staff were recorded as having been appraised in August 2013. There was no record for the other two administrative staff or the consultants. The staff we spoke with reported they had an annual appraisal in the last year. However, the data did not indicate that staff had received an appraisal in 2013/14.
- Revalidation was carried out in line with professional body requirements; the lead consultant told us they had received 360 degree feedback as part of the process. The process includes getting confidential feedback from line managers, peers and direct reports. As a result, it gives an individual an insight into other people's perceptions of their leadership abilities and behaviour.

End of life care

- The Commissioning for Quality and Innovation (CQUINs) payments framework was set up in 2009/2010 to encourage care providers to share and continually improve how care is delivered and to achieve transparency and overall improvement in healthcare. In 2013/14 the trust had a CQUIN target that 95% of staff had received basic EOLC awareness training – data showed 95% of nursing staff had attended the training but only 37% of doctors had. Overall 73% of trust staff had attended.
- Training sessions were provided by the SPCT across the hospital and community with sessions identified for Junior Doctors for topics such as introduction to palliative care, recognising & managing EOLC and symptom control. Sessions were also provided to raise awareness of end of life care in A&E and elderly care across the trust.
- Some ward managers reported they supported staff to complete palliative care courses.
- Staff attended the national training programme in advanced communication skills, to support staff in having difficult conversations with patients and relatives.
- We were told there had been a system of link nurses who were trained in end of life care and monthly training had been provided. However this had been put into a 'holding position' while the trust's review of the Liverpool Care Pathway was currently under way.
- There was an annual trust study day for end of life care and the SPCT consultant told us the last one held covered the guiding principles.
- The bereavement officer was a trained bereavement counsellor.
- Newly qualified nursing staff told us they had received some EOLC teaching during their training.

Multidisciplinary working

- The trust was the same as the average England score of 59% for multi-disciplinary team recognition that the patient was expected to die within the coming days or hours.
- The SPCT attend weekly MDT meetings with all site specific cancer teams as well as with the Acute Oncology Service.
- The team attended joint meetings with the Neurology team and community adult rehabilitation team for patients with advanced Parkinson Disease, Motor Neurone Disease & Multiple Sclerosis.The consultants carried out weekly ward rounds at Hayes Cottage, a local nursing home which has dedicated palliative care nursing home beds. There was no evidence of associated allied professionals or social workers attached to the team.
- However as occupational therapist representative attended the weekly palliative MDT meeting. The SPCT liaises with ward / department based teams to support staff in the delivery of care 'Coordinate My Care' (CMC) is an electronic recording system used to share information between patients' healthcare providers, such as GP, hospitals and ambulance. It allows health professional know the patient's wishes of how they would like to be cared for. The SPCT were early adopters of this system.. The team reported access to the system was currently restricted to the palliative care team.
- Training sessions were provided across the trust to raise awareness of the CMC and to encourage its use to improve communication and patient's experiences of care if they were admitted to hospital.
- Ward staff had multi-stage handovers, office and at bedside shift changes and ward to board handovers as necessary. Handover sheets were distributed to ensure details of patient's care needs were updated and communicated to the team.

Seven-day services

- The SPCT provided advice and support Monday to Friday 8am to 4pm and consultant cover out of hours was through an on-call rota.
- Staff were able to contact the local hospice (Michael Sobel House) for advice out of hours.

Are end of life care services caring?

Good

End of life services were caring. Patients were treated with compassion, dignity and respect. Patients and relatives spoke positively about their care. There was some evidence of advanced care planning taking place with patients who were in the last year of life.

We saw evidence that the palliative care team and other medical teams such as care of the elderly had discussions with patients and their families about their end of life care choices when admitted to the hospital. Patients and relatives felt involved in their care.

End of life care

Portering and mortuary staff were respectful to deceased patients and talked sensitively about escorting relatives, preparing the room and the deceased patient for viewing.

Compassionate care

- The key outcome measure in the National Care of the Dying Audit Hospitals (NCDAH) Local Bereaved Relatives Survey published in May 2014 showed that the majority of the nine respondents were likely to recommend the end of life care at The Hillingdon Hospitals NHS Foundation Trust.
- Seven of the nine respondents said their relatives had enough help with nursing care such as medication and being kept comfortable.
- All relatives asked said they had confidence and trust in the nursing and medical staff caring for the patient.
- Six out of nine respondents said the doctor had time to listen and discuss the patient's condition.
- Porters escorted relatives with nursing staff to the mortuary from the ward where the patient had died.
- We spoke with 12 nursing staff. There was a mixed response from them with regard to the kind or care and support they would offer patients coming to the end of their life. Some of them found it hard to explain how they would support a dying patient and their family, while other staff described how they would make a patient comfortable, maintain their dignity and keep them company if they were alone. Some had been link nurses previously and had retained an interest in delivering good quality care to patients and supporting relatives during the last days of a patient's life.
- During our inspection we saw patients being treated with compassion, dignity and respect. We observed a member of nursing staff offer to help a patient drink and heard them speak gently and reassuringly while enquiring how they were feeling.
- A relative shared their experience of the care their family member received during the last stages of their life. They described the care they received in A&E, EAU and on Jersey Ward as being "outstanding".
- Nurses told us patients at the end of life without relatives or friends received one to one care and were not left alone.
- Porters and mortuary staff were respectful to deceased patients and talked sensitively about escorting relatives, preparing the room and the deceased patient for viewing.

Patient understanding and involvement

- The trust scored 85% in the NCDAH which was 11% better than the national average for health professional's discussions with both the patient and their relatives / friends regarding their recognition that the patient is dying.
- A relative we spoke with told us that the consultants, doctors and nursing staff were very clear in explaining that their relative was reaching the end of their life.
- The trust scored 69% (12% higher than the national average) for communication regarding the patient's plan for care of the dying phase. A relative confirmed that staff discussed how their relative would be cared for in the last days and hours of their life. They described how the family had been involved in all discussions relating to their relatives care. They told us that while their relative was fairly unresponsive the staff ensured they directed their conversation to include their family member too. They felt able to ask any questions they had and these were answered by staff appropriately.
- Patients referred to the SPCT have CNS assigned to them.
- The trust 'Policy & Guidance for the provision of Care & Respect in Death' provided staff with the information on how to provide patients with the opportunities to create an advanced care plan, including EOLC wishes and any advanced directives.

Emotional support

- The trust's score in the NCDAH for Assessment of the spiritual needs of the patient and their nominated relatives or friends was 12% which was worse than the national average of 37%.
- A relative we spoke with told us they were not aware of being asked if the patient or their family had any spiritual needs or specific requests. They were not aware of the chaplaincy support that could be offered.
- The SPCT psychologist was available to provide emotional and counselling support.
- Clinical nurse specialists for cancer patients were in post and there was access to palliative care clinical nurse specialists. There was a Macmillan cancer information centre where patients and their families could get emotional support and advice on how to live with cancer.

Are end of life care services responsive?

End of life care

Requires Improvement

The specialist palliative care team (SPCT) provided care across the hospital and community but did not have the resources to provide a seven day service. There was limited evidence of a trust wide approach to deliver end of life care that was not reliant on the SPCT.

It was not always possible to care for patients in side rooms during their end of life care. There were very few rooms available to have private conversations with patients and relatives and the waiting area for relatives / families attending the bereavement office did not provide any privacy. The SPCT were able to arrange rapid discharge arrangements to patients with limited life expectancy to their home, Hayes Cottage or the local hospice.

The trust used the national early warning score (NEWS) to identify deteriorating patients. Individual care plans were used to identify which observations or monitoring was appropriate during the person's end of life care. However, we saw examples where patients continued to be subject to the NEWS and triggering responses, despite being identified as being at the end of their life and requiring palliative support.

The SPCT were able to arrange rapid discharges, however, this was not always available for all patients who wanted to leave hospital to die in a different location. Staff, however, made every effort to meet patient wishes.

There was access to spiritual support and there was a chapel and multi faith room available.

Service planning and delivery to meet the needs of local people

- The SPCT supported 664 patients attending the hospital during 2013-14. During the same period there were 700 deaths in the hospital and the SPCT provided support to 200 of those patients.
- Around 60% of these cases were non-cancer patients. The SPCT told us they had seen an increase in the number of referrals to their service, and they was some concern they would not be able to support the increase in demand without employing more specialist staff or having clinical staff trained in EOLC on the wards.
- The SPCT confirmed there was integrated working between the hospital, wards and community staff. The SPCT consultants carried out on-site ward rounds at Hayes Cottage to patients transferred to these continuing palliative care beds and did community based outpatient clinics.
- The team told us they would be contacted when a known patient was admitted to hospital.
- Patients with lung or gastric cancer were referred to a CNS who were involved throughout their care to end of life in the acute setting. The SPCT have identified the need to reduce staff reliance on the team to support all patients at the end of life.
- The local strategy was to increase the numbers of patients dying in then place of their choice, however, the lead consultant recognised there was more work to be done to improve end of life care in the community supported by GPs.

Access and flow

- Patients were referred to the SPCT by any healthcare professional working in the trust and community. The teams worked closely together and were based in the same offices which aided communication.
- 92% of patients were seen within 24 hours of referral.
- Patients were admitted to hospital through A&E, outpatients or direct referral by a GP.
- The SPCT were able to arrange rapid discharge arrangements to patients with limited life expectancy to their home, Hayes Cottage or the local hospice. However rapid discharge to home was dependent on many factors including equipment, transport and the timeliness of prescribing medicines to take away (TTA).
- Ward staff reported there were delays in the dispensing of patients medicines which had on occasion delayed patient's discharge from hospital.

Meeting people's individual needs

- The trust used the national early warning system (NEWS) to identify deteriorating patients. However, individual care plans should identify which observations or monitoring was appropriate during the person's end of life care. We saw examples where patients continued to subject to a NEWS triggering responses, despite being identified as at the end of their life and for palliative care.
- The trust did not achieve the national target for 'providing specialist support for care in the last hours or days of a person's life'. This was because they did not provide face to face specialist palliative care services

from 9am to 5pm seven days a week although there is a national recommendation that this should be provided. Nationally 21% of NHS trusts achieved this. However there was 24 hour access to on call advice from the consultants and local hospice.

- Staff told us there were no rooms available for 'difficult conversations' or breaking bad news.
- One family member told us discussions did not take place in private. However, they said they did not feel the discussions were overheard by others as discreet conversations were held by their relative's bed.
- There were no beds specifically identified for end of life patients, staff reported they tried to identify side rooms to provide privacy. These were a scarce resource as most were used for patients needing isolation.
- Children, mainly oncology patients, were able to die on the children's inpatient ward if this was the parent's wish. Families could also be referred to a hospice.
- Staff and relatives we spoke with told us there were no visiting restrictions for patients in the last days and hours of life. A family member confirmed they were not restricted in the times they saw their relative during the last days of their life.
- Family rooms and overnight accommodation was not available other than in the children's ward.
- There was a chaplain employed in the trust who offered multi-faith spiritual support to patients and relatives. There were arrangements in place to contact faith specific religious support when needed.
- There was a chapel and a multi-faith room available for use 24 hours a day.
- Deceased patients were transported to the mortuary on their bed covered by an adjustable frame with a cover that can be used for all patients. This allowed greater dignity to the deceased patient and reduced the need to handle the body.
- Bereaved relatives were given an information booklet providing guidance on what to do and expect after a death. A relative told us it was a useful guide as they were unaware of what happened and who needed to be contacted.
- The chaplaincy service had introduced additional support including a patient information leaflet for families who have lost pre-viable pregnancies.
- Bereaved relatives were provided with an appointment time to attend the bereavement office to collect certificates and personal effects. There were a few chairs in the corridor outside of the office for them to wait to be seen which were overlooked by an occupied office.
- The bereavement officer saw relatives in a small, private room which was separate to the main office. Patient effects were stored in secure lockers that were shielded from view by curtains.
- The mortuary viewing area was clean and sparsely decorated. The mortuary technicians were alerted to prepare the area before families were accompanied to the viewing room.

Learning from complaints and concerns

- The specialist palliative care team had not received any complaints or concerns raised by staff, patients or relatives in relation to end of life care.
- The complaints procedure was displayed around the hospital with details of whom to contact about concerns.
- The bereavement office reported that they received a few complaints with regard to accessing spiritual support, particularly out of hours, and wards responding to some cultural needs.

Are end of life care services well-led?

Requires Improvement

There was no trust strategy for end of life. Up until very recently end of life care did not have a high profile in the trust. There was no trust policy or strategy for end of life care. However, the trust is part of the Hillingdon borough end of life strategy for 2013 to 2016. The end of life care priorities identified in the action plan were driving the trust's future strategy. The hospital SPCT had an annual work plan detailing service developments which is part of the National Peer Review requirement.

Staff reported a lack of engagement with senior management in regard to this service. However, an executive director with the lead for end of life care had recently been appointed. The executive director and SPCT told us they were in agreement that "EOLC should be everyone's business and not just the responsibility of the

End of life care

SPCT". However only one meeting had taken place in August 2014 and there were concerns that the committee would lose momentum and would not take off and lead on EOLC within the trust.

There were limited governance systems in place although some audits had taken place. The SPCT reported an increasing workload with no review of staffing levels to meet the demand.

There was evidence of collaborative work with the CCG and others with the development of the integrated strategy to improve the planning for end of life care across primary and secondary care to ensure more patients were able to die in the place of their choice. The trust's scores from the NCDAH were discussed at the inaugural end of life committee in August 2014. An action plan was drawn up prioritising the areas of concern in September 2014. There was no evidence of any changes having been implemented at the time of the inspection.

We found the lead palliative care consultant was providing good leadership at a local level and they told us about their vision for the service and hope that with the involvement of the executive team, there would be an increased focus and drive to improve end of life care for patients. We found there was good leadership on some wards where senior nurses supported staff in providing high quality care to patients at the end of their life.

Vision and strategy for this service

- There was a nominated executive lead for end of life care. The SPCT were looking to recruit a lay person to the end of life committee.
- There was no documented vision and strategy for the service. However the lead cancer physician told us that end of life care could not be driven by the SPCT and must be driven by the board in conjunction with specialist services such as care of the elderly, chaplaincy and SPC.
- The lead SPC consultant told us the priorities identified in the Hillingdon End of Life Care Strategy 2013 to 2016 would drive the end of life work streams in the hospital but this was still an aspirational plan.

Governance, risk management and quality measurement

- The Hillingdon End of Life Forum was responsible for monitoring the integrated strategy.
- We were told the trust's end of life care committee would be responsible for monitoring the trust's work steams going forward.
- The Director of Nursing was the lead for end of life care with the nursing director as the overall operational lead for end of life care throughout the trust. The palliative care consultant supported the clinical decision making for each patient with their main core service consultant as appropriate.
- End of life care did not have a service specific performance dashboard and we found no evidence of it featuring in any of the trust performance measurements.
- Clinicians told us there had been mortality meetings and all deaths were reviewed as part of the process. Service improvements were planned in response to lessons learnt as part of the review process.
- We found no evidence of end of life care issues on the local or overall trust risk register. The SPCT told us they had seen an increasing workload without a review of staffing.
- The SPCT could verbalise the risks within their service and sphere of responsibility. They expressed a view that they hoped the end of life care committee would be the forum in which governance, risk and quality issues would be reviewed and to drive improvement in end of life care across the trust.

Leadership of service

- The SPCT service had an identified a clinical lead that was supported by the other consultants and CNS.
- The trust had recently identified the director of nursing as the executive director to lead the end of life care committee. There did not appear to be a consensus between the Director of Nursing and the palliative care team as to who held the lead for the operational oversight of end of life care.
- The SPCT had been consulted on the draft of the trust's "Policy and Guidance for the provision of Care & Respect in Death" but were unaware that it had been ratified in August 2014. The SPCT had asked that the new policy be discussed again as soon as possible in the next end of life care committee.

Culture within the service

- The SPCT reported there were good working relationships within the team and community services.
- Staff across the trust felt able to contact the team for advice and support.

End of life care

- The SPCT wanted to develop an end of life care culture which was less dependent on the specialist team.

Public and staff engagement

- Nine relatives had contributed to the trust NCDAH local survey for bereaved relatives. According to the report published in May 2014 the majority of people felt they and their relative had received sufficient care, support and advice during the final stage of their life.
- The bereavement office sent an 'experience survey' requesting bereaved families to comment on their experience of the bereavement office and mortuary. This had been introduced three months prior to our inspection.

Innovation, improvement and sustainability

- The team worked with Hillingdon End of Life Forum to develop and implement an integrated end of life care service in the borough.
- Through the forum, the SPCT have engaged regularly with commissioners and community services such as district nursing and age concern.
- The SPCT have set up and managed 10 intermediate beds within a local nursing home funded by continuing care money for patients within the last few weeks / months of life.
- Neuro services were integrated across primary and secondary care. For patients with advanced neuro-degenerative disease this included a regular MDT attended by both community and hospital staff to discuss patients with advanced disease from across the borough.
- The SPCT secured the funding for, and set up an acute oncology service until the appointment of an oncology consultant and CNS.

Outpatients

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

Information about the service

The Hillingdon Hospitals NHS Foundation Trust saw around 292,615 patients in outpatients (OPD) last year. Clinics took place on either the Hillingdon Hospital site or the Mount Vernon Hospital site. Patients would be directed to the hospital site that their clinic was located in at the time of their booking. Ophthalmic clinics were also seen at both hospital sites, but also had some clinics located within community settings as the eye clinic environment was not large enough to meet with the demand on the service.

The OPD ran clinics across both hospital sites in general surgery, urology, breast surgery, colorectal surgery, vascular surgery, trauma and orthopaedics, ear, nose and throat (ENT), ophthalmology, oral surgery, orthodontics, plastic surgery, paediatric surgery, thoracic surgery, anaesthetics, pain management, paediatric urology, paediatric trauma and orthopaedics, paediatric ophthalmology, paediatric clinical haematology, paediatric dermatology, paediatric respiratory medicine, paediatric medical oncology, paediatric diabetic medicine, paediatric cystic fibrosis, general medicine, gastroenterology, endocrinology, haematology, hepatology, diabetic medicine, clinical genetics, rehabilitation, palliative medicine, allergy service, cardiology, transient ischaemic attack, dermatology, respiratory medicine, nephrology, medical oncology, neurology, rheumatology, paediatrics, care of the elderly, obstetrics, gynaecology, obstetric-midwife, podiatry, dietetics, orthoptics and clinical oncology.

Summary of findings

We found that letters to general practitioners (GPs) were not being sent within the five-day period in line with trust policy. On the day of our inspection, the majority of medical secretaries were not typing letters within this timeframe.

The renal outpatients department (OPD) was unable to provide patients with follow-up appointments in a timely manner.

The ophthalmology clinic was not an ideal environment, as it was too small to meet with the demands of the service. Although the trust had attempted to mitigate the issue by running extra clinics within the community, this issue was still evident at the Hillingdon Hospital site.

The trust was very responsive when planning the service to meet the needs of local people. Effective consultation allowed the service design to meet the needs of local communities and staff groups. We saw good ownership of the care and treatment they delivered by staff of all grades.

A proactive stance was taken in addressing issues that impacted on care delivery, such as developing a policy to monitor and reduce non-attendance at hospital appointments. In general, resources and facilities were good and met the needs of people attending the department.

We found that the OPD was accurately monitoring patient pathways. The central booking service was consistently able to give patient appointments within

Outpatients

the NHS England and Clinical Commissioning Groups 2012 regulations about 18-week referral-to-treatment targets. We were able to see evidence of clear strategies to monitor and maintain systems to ensure that the trust met with these targets. The trust was consistently meeting with the two-week wait timescale for patients with urgent conditions, such as cancer and heart disease. We were able to see evidence of clear strategies to monitor and maintain systems to ensure that the trust met with these targets.

We found good local leadership within the OPD departments. The OPD matron was praised highly by staff who felt that they were proactive and supportive.

Are outpatient and diagnostic imaging services safe?

Good

Staff were consistently reporting incidents through an incident reporting system widely used by NHS organisations. We saw evidence that staff learned from trends in incident reporting and learning was fed back to all staff groups within the department.

Staff were adhering to policies and procedures relating to infection prevention and control.

Equipment was maintained and available where needed.

Medicines had been stored and prescribed in a way that complied with relevant legislation.

Records had been stored securely and were mostly available when required.

Staff had received mandatory training, in line with the trust's policy. Staff were able to demonstrate a good understanding of safeguarding procedures.

Through staff goodwill and willingness to work extra hours, the department was able to demonstrate that clinics were adequately staffed.

Incidents

- At the time of our inspection visit, there had been no recent serious incidents or Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) relating to the outpatients department (OPD).
- Trust policy stated that incidents should be reported through the incident reporting system which enabled incident reports to be submitted from wards and departments. We saw a breakdown of incidents by category and date that allowed trends to be identified and action to be taken to address any concerns.
- The manager told us that, once they had submitted a report the person investigating would send an email outlining their investigation outcomes. However, they said that they did not consistently receive this feedback.

- The OPD Sisters told us that they would feed back any learning to staff. They said that they did this during department meetings. We saw the minutes of these meetings, which confirmed that learning from incidents was discussed.
- Staff gave us examples of where the delivery of patient care had been changed due to learning from incidents.

Cleanliness, infection control and hygiene

- 91% of staff in OPD had completed mandatory training in infection prevention and control in line with the trust's policy.
- There were hand hygiene and 'bare below the elbow' audits undertaken, which demonstrated staff were compliant with best practice guidance. These were done for each clinical area, and documented in the annual clinical governance report.
- Staff working in the OPD had a good understanding of responsibilities in relation to cleaning and infection prevention and control.
- Clinical areas were monitored for cleanliness by the facilities team. Cleaning audit scores for the past three months were recorded at 95% or above for all clinic areas. This meant that they met with local required standards of cleanliness. The trust did not audit against national standards of cleanliness, but audits showed that they met the requirements in outpatients.
- Housekeeping staff could be called between scheduled times to carry out additional cleaning, where staff felt it was necessary. We noted that although the cleaning audit scores met with expected cleaning standards, we found some dust on high surfaces, and ingrained grime around door stops and in the corners of the floor in some areas.
- In some areas, the flooring did not meet with required standards, due to damage or gaps in the corners and edges of rooms, which had accumulated dirt and grime.
- Nursing staff were responsible for cleaning clinical equipment. We saw that there were checklists in place and they were completed to provide assurance that this was done.
- The equipment that we saw was in good repair and the green labels the trust used to indicate that equipment had been cleaned were in use.
- The staff we observed in the OPD were complying with trust policies and guidance on the use of personal protective equipment and were 'bare below the elbows'.
- We observed staff in the main OPD washing their hands in accordance with the guidance published in the 'Five Moments for Hand Hygiene' guidelines published by the World Health Organization.

Environment and equipment

- All mobile electrical equipment that we looked at had current portable appliance testing certification.
- All equipment in the OPD was updated and maintained through contracts with external providers for specialist equipment. A register was kept of the contract arrangements.
- We saw that there was adequate equipment. Staff told us that there was not a problem with the quantity or quality of equipment and that replacements were provided when necessary.
- The environment was reasonably well maintained, although we did see worn flooring in some areas.

Medicines

- Medicines were stored in locked cabinets within the department. All medicines were ordered by nursing staff through the hospital's pharmacy.
- The majority of medicines were administered by doctors. When nurses were required to administer medicines such as analgesia, these would be prescribed by the clinician and recorded on a prescription chart, which would be stored in the patient's medical records. The nurses would then sign and date the prescription to confirm that they had administered the medication.
- FP10 prescription pads were stored in a locked cabinet. When clinicians wrote patient prescriptions the OPD kept a log, which identified the patient, the doctor prescribing and the serial number of the prescription sheet used. This ensured the safe use of prescription pads.

Records

- The matron told us that the department had experienced issues with obtaining patients' health records during a recent relocation of the trust's storage of health records. However, they said that, since the initial teething issues, they had now seen that the supply of health records had improved and was no longer an issue for the department.
- The matron told us that staff were expected to report on each occasion that health records were unavailable for clinic. They told us that they shared any learning from misfiled notes during staff meetings.

Outpatients

- All of the staff we spoke with confirmed that they would report these types of incidents. Where notes had been unavailable this had been investigated through the incident reporting system. Records confirmed that although there had been an issue with the availability of health records for a short while during the relocation of the medical record storage, these incidents had decreased. In the past three months there had been eight reported incidents of missing health records across OPD.
- We spoke with staff from medical records management, who told us that they were sometimes tasked with these investigations. They said, though, that it was not always possible to trace where the notes had been misfiled. Where they were able to establish a cause, this would be passed on to the departments manager for action.
- The OPD had a porter responsible for transporting patient records to and from the department.
- During our inspection, we saw that health records and patients personal information was stored securely in all areas of OPD.

Consent, Mental Capacity Act 2005 and Deprivation of Liberty Safeguards

- Staff did not receive specific training on the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards, but told us that they covered these topics during their safeguarding training.
- The sisters that we spoke with demonstrated an understanding of the legislation and their role in relation to this legislation. However, other staff we spoke with had a limited understanding of their role and responsibilities in relation to the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards.
- We viewed three consent forms during our inspection, which had been completed correctly by staff.

Safeguarding

- OPD staff were encouraged to contact the safeguarding lead if they had any concerns about patients. Staff assured us they knew who the trust safeguarding lead was and how to contact them.
- 83% of staff working in the OPD had completed mandatory safeguarding training to level 2, and 86% had completed child protection training to level 2. Staff were able to talk to us about the insight and knowledge they had gained from this training. They were also able to show us the trust safeguarding policies on the intranet.
- An OPD sister was able to give us an example of when staff in the department had followed the trust safeguarding policy and made an appropriate referral.
- The matron described to us how the department managed children who did not attend clinic that were on a child protection plan. The computer system alerted staff who contacted the child's key worker and GP to report that they had not arrived for a clinic appointment.
- The trust had a chaperone policy that was followed by the OPD staff.
- The trust had a whistleblowing policy that was known to staff that we spoke with working in the OPD.

Mandatory training

- Mandatory training records were completed electronically. The system flagged up to staff and managers when mandatory training was required.
- Records showed that 77% of OPD staff had completed fire safety training, 90% of OPD staff had completed health and safety training, 91% of OPD staff had completed moving and handling training, 88% had completed conflict resolution training and 87% of OPD staff had completed information governance training.
- All of the staff we spoke with confirmed that they had received their mandatory training in line with the trust's policy.

Management of deteriorating patients

- Staff that we spoke with were aware of their role in a medical emergency. We spoke with a staff nurse who talked us through what they had done during a recent medical emergency within their department, demonstrating that they acted as necessary.
- 83% of OPD staff in the department had received adult resuscitation and life-support training within the last year. 86% of nurses in the main OPD had received paediatric life-support training.
- We saw evidence that adult resuscitation equipment stored in the department to assist staff during an emergency had been checked regularly by staff. Staff had signed to say that the equipment had been checked, was available and within its expiry date. We were shown the procedure for checking the resuscitation equipment.

Nursing staffing

- The OPD ran extra clinics on an ad-hoc basis in order to manage the waiting lists. These clinics were staffed

mainly from the OPDs regular staff, who were required to work flexibly and were able to work bank shifts over and above their working hours to accommodate the extra clinics.

- The OPD had accommodated extra clinics by lengthening the working day and opening at weekends. Staff had gone through a consultation period to ensure that their contracts reflected the changes in their working patterns. The matron told us that, although this had been difficult for some staff, they had managed to accommodate requests from staff to ensure that they were able to manage the changes within their required working conditions.
- The department used regular bank staff to fill spaces on staffing rotas. The department was reluctant to use agency staff that had not worked in the OPD before, as they were not trained in the specific competencies required to work within the department.
- The matron told us that staff were very accommodating about swapping shifts and working extra bank hours to ensure that clinics were covered by staff with the correct skills. They said, "I am so proud of my staff, they are flexible and drop everything when asked to go and help in another clinic, sometimes even our other hospital site. We manage because of the goodwill of our staff."

Medical staffing

- The medical cover for clinics was arranged within the divisions who agreed on the numbers of clinics and patient appointment numbers.
- Trust policy states that medical staff give six weeks' notice of any leave in order that clinics could be adjusted in a timely manner. The sisters informed us that most doctors adhered to this policy. They said that if clinics were cancelled at short notice outside of the requirements of the trust policy this would be reported through the system and investigated by divisional leads.
- None of the staff we spoke with felt that there were any issues with medical cover for clinics.
- The doctors that we spoke with told us that they were happy with the support that they received from the department.

Major incident awareness and training

- The trust had a major incident plan, which was available to staff on the intranet.
- Staff were able to describe to us their role in a major incident. We saw evidence that the major incident plan was discussed at staff meetings.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

The department adhered to guidance provided by the National Institute for Health and Care Excellence.

The department ran a continuous patient experience survey, which patients were encouraged to complete following their visit to the department and the results of these surveys were shared with staff and patients.

Staff valued the appraisal process and felt supported to attend training but nearly half of staff were not receiving a local induction and more than half the staff in some clinics had not had a recent appraisal.

The department made relevant referrals to services such as osteoporosis specialist nurses, occupational therapists, orthotics and the psychiatric liaison service, when appropriate.

The department had extended clinic times to weekends and evening clinics. Diagnostic services also ran at weekends to support the clinics.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidance for smoking cessation had been met within the department. The OPD assessed each patient who accessed the service to establish whether they would benefit from a referral to the smoking cessation service. Staff would refer patients to the service where a need was established. We spent time in the smoking cessation clinic during our inspection. Patients were encouraged to attend weekly and given advice and smoking cessation aids in order to support them.
- National Institute for Health and Care Excellence (NICE) guidelines for macular degeneration had been met in the ophthalmology OPD. The department had ensured that patients referred into the service had been given an optical coherence tomography (OCT) and had seen the consultant and started on a five-week treatment plan, where needed, within two weeks of referral.

- National Institute for Health and Care Excellence (NICE) guidelines for diabetic macular oedema had been met in the ophthalmology OPD. The department had also ensured that patients had been seen by the consultant and received diagnostic tests within two weeks of referral.

Patient outcomes

- The OPD ran a continuous patient experience survey, which patients were encouraged to complete following their visit to the department.
- Results of these surveys were shared with staff and patients on display boards within the departments.
- The OPD used these boards to display a 'You said, we did' section – used to tell patients about things that they had said and what the department was doing to improve this for them.

Competent staff

- Along with mandatory training, staff in OPD were expected to demonstrate competencies in the areas that they worked in. We were shown competency assessments for clinical nurse specialists working in ENT.
- Staff attended a trust induction followed by a local induction in the OPD on starting work at the service. 55% of staff had attended a local induction in the previous year and 100% of staff had attended the trust's corporate induction.
- Staff appraisals varied across different areas of outpatients. Staff were expected to receive an annual appraisal. In ophthalmology and ENT outpatients, none of the staff were up to date with their annual appraisal, in the main outpatients 41% of staff were up to date with their appraisal, oral surgery and orthodontic OPD 71% of staff were up to date and in the trauma and orthopaedic OPD 42% were up to date.
- We spoke with healthcare assistants, staff nurses and sisters, who told us that they valued their annual appraisal and felt that their developmental needs had been recognised, and supported through learning.
- Band 6 staff and above were very positive about a professional talent management element that had been applied to their most recent appraisals. This aspect of their appraisal had assisted them to understand and develop their training needs as managers, and had encouraged them through training that best identified with their skills and talents.

Multidisciplinary working

- The service ran a number of one-stop clinics where patients were seen by members of the multidisciplinary team (MDT) in one clinic. We spent time in the micrographic facial surgery (MOHS) clinic during our inspection. In this clinic, patients were treated by consultants and specialist nurses, with the support of the hospital's laboratories to ensure that patient treatments were completed in one day.
- Several samples could be sent to the laboratories several times during the day, to ensure that the correct amount of tissue and all cancerous cells were removed from the patient's face.
- The OPD made relevant referrals to services, such as osteoporosis specialist nurses, occupational therapists, orthotics and the psychiatric liaison service where appropriate.

Seven-day services

- We were told that, where it was identified that the demand for clinics was greater than the clinic appointments available, the trust would create further clinics to absorb the extra appointments needed.
- OPD had extended clinic times to weekend and evening clinics. Diagnostic services also ran at weekends to support the clinics.
- Three patients told us how pleased they were to be offered an appointment for a Saturday morning.

Are outpatient and diagnostic imaging services caring?

Good

We saw very caring and compassionate care delivered by all grades and disciplines of staff working at Hillingdon Hospital. Staff offered assistance without waiting to be asked. Staff worked hard to ensure patients understood what their appointment and treatment involved.

Compassionate care

- One of the strengths of the service in the OPD was the quality of interaction between staff and patients.
- We watched staff assisting people around the different OPD areas. Staff approached people rather than waiting for requests for assistance, asking people if the needed assistance and pointing people in the right direction.

Outpatients

- We saw staff spending time with people, explaining care pathways and treatment plans. We noticed that staff squatted or sat, so that they were at the same level as the person they were speaking to in the reception area and maintained eye contact when conversing.
- We observed staff interactions with patients as being friendly and welcoming. We saw staff stopped in clinics to greet patients that they knew and ask after their wellbeing. We observed that patients that attended clinic regularly had built relationships with the staff that worked there.
- Staff were trained and expected to keep patients informed of waiting times and the reasons for delays. We observed this happened in all areas of the OPD during our inspection.
- All of the patients we spoke with were complimentary about the way the staff had treated them. A patient said, "It's really good, the staff are lovely." Another patient said, "I can't fault them."
- Patients also told us that they had been treated with dignity in the department. One patient told us, "I have always been treated with respect."
- The OPD reception was in the OPD waiting area. The area was busy with patients arriving for appointments. There were signs to prevent people from crowding around the desk. Reception staff told us that when patients arrived for appointments their name, date of birth, address, and telephone number were checked with them at this desk. The receptionist told us that, as they checked patients personal information, they ensured that other people stood back so that they could not be overheard. This showed that staff had considered ways to ensure that patients' personal information was protected.
- All of the clinic rooms had privacy signs on the doors. We saw that staff adhered to these signs and always knocked and waited for permission before entering rooms.

Patient understanding and involvement

- We spent time in the department observing interactions between staff and patients.
- All of the patients we spoke with told us that their care was discussed with them in detail, and in a manner that they were able to understand. Patients told us that they felt included in decisions that were made about their care and that their preferences were taken into account.
- We saw literature being explained to patients in the MOHS clinic. We saw patients being handed detailed information which was explained to them by nurses who checked their understanding. Nurses also ensured that patients had a contact number to call if they had further questions or concerns when they returned to their homes.
- There were patient leaflets in each waiting area, which provided patients with information about the department, how they could complain, and information on diseases and medical conditions. We saw patients reading this information. When asked, they all said that the information was in a format that they understood.
- Patients could opt to receive a copy of the letter that was sent to their GP, this outlined what had been discussed at their appointment and any treatment options. They did this by completing a consent form available at the reception desk. Most of the patients we spoke with were unaware that they were able to do this. We did not see this service advertised to patients during our inspection.
- We also observed the doctors behaving in a friendly and respectful manner towards the patients in their care.
- The service provided chaperones, where required, for patients. We were told that staff were always available for this.

Emotional support

- The OPD was a calm and well-ordered environment, although at busy times, waiting rooms became overcrowded. We saw nurses constantly updating patients on clinic waiting times and checking that patients were comfortable and happy. One patient said, "My appointment is delayed, but they have offered me a cup of tea, which I think is very kind."
- We saw one person becoming distressed in the department after being given difficult news. Staff were quick to respond and took the patient to a quiet room set aside for patients who were upset. We saw staff supporting the patient in a kind, caring, and supportive manner.
- We saw another example of staff supporting a frail, elderly patient with compassion and dignity. The patient was very tired from their journey to the department and staff ensured that they were seen immediately, and supported during their stay in the department.

Outpatients

- We also observed a patient who appeared to be in pain. We saw that staff recognised this and went to assist the patient promptly and discreetly.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

We found that letters to GPs were not being sent within the five-day period in line with trust policy. On the day of our inspection, the majority of medical secretaries were not typing letters within this timeframe.

Follow-up appointments were not being given to patients in a timely manner in the renal service. This could mean that patients were not being monitored safely where a medical need had been identified.The ophthalmology clinic was not an ideal environment, as it was too small to meet with the demands of the service. Although the trust had attempted to mitigate the problem by running extra clinics within the community, this issue was still evident at the Hillingdon Hospital site.

The trust was very responsive when planning the service to meet the needs of local people. Effective consultation allowed the service design to meet the needs of local communities and staff groups. We saw good ownership of the care and treatment they delivered by staff of all grades.

A proactive stance was taken in addressing issues that impacted on care delivery, such as a developing an appropriate policy to monitor and reduce non-attendance at hospital appointments. In general, resources and facilities were good and met the needs of people attending the department.

Service planning and delivery to meet the needs of local people

- The OPD entrance to the hospital led into an unstaffed lobby with a noticeboard directing patients to their required area. There was a talking information board inside the entrance that directed people in a variety of languages to areas of the hospital. There was signage directing people to the correct areas of OPD. However, we saw many people who were unsure of where they needed to go.
- The ambulance transport liaison office was located in the lobby and we observed many people asking ambulance staff for directions around the hospital. We spoke with ambulance staff, who confirmed that they were constantly asked for directions around the hospital by members of the public. They said that, as a consequence of this, they had erected a glass screen at the front of their office to dissuade people from asking. However, they told us that people still came to the door at the side of their office to ask for directions.
- We found that, in most areas, there was seating available for patients. The ophthalmology waiting area was cramped and crowded. Despite this, when we inspected, all of the patients in this area had a seat. However, we were told that at very busy times this was not always the case.
- All of the staff we spoke with acknowledged that the department was not large enough to cater for the demand on the clinic. As a result of this, the OPD was trying to see patients either at the Mount Vernon Hospital site or in clinics in the community, which had been set up as a direct result of the issues around space.
- The matron demonstrated that staff had put a lot of thought into this issue. The matron felt that the only suitable long-term solution would be to have a purpose-built unit for ophthalmology.
- We had multiple complaints regarding car parking at the hospital. We were told that the trust was hoping to improve the situation by adding a new level onto the car park.
- Throughout our inspection, we saw cars queued up waiting to gain access to car parks on site. Three patients told us that they had to arrive two hours before their appointment time in order to get a space in the car park. Two patients who were disabled parking disc holders told us that they found it very frustrating as they could see that spaces were available for them in the car park, but they were forced to wait in the queue of people waiting for a space to become available before being allowed to enter the car park.
- Staff told us that, because they were aware of the parking issues, they were flexible with patient appointments when they had been held up waiting for a car parking space.
- On one morning of our inspection, we noted that one clinic was running late. We were told that the doctor was still trying to park their car and had been doing so for

forty minutes. We were shown an incident report from the day before that showed a clinic had started two hours late because the doctor had been unable to park their car.

- The trust ran a free shuttle bus between the Hillingdon Hospital and Mount Vernon Hospital sites. We spoke with passengers using the shuttle bus, who told us that they had heard about it through word of mouth. We were able to find leaflets advertising the shuttle bus service when we asked for them at the main reception of the hospital. However, these were not displayed in the OPD. Patients we spoke with in the department were unaware that this service was available to them.

Access and flow

- We found that letters to GPs were not being sent within the five-day period in line with trust policy. On the day of our inspection, the majority of medical secretaries were not typing letters within this timeframe. Oral surgery were typing letters four to five weeks after patient appointments, the urology secretaries three weeks after, ophthalmology had notes waiting from the 19 September with no one available to type the letters, as the secretary was on sick leave and had no one to cover her work. The renal secretary was typing letters from the 6 August on the day of our inspection and told us that once typed letters would take a further week to be signed by the consultant. Another medical secretary told us that their consultant took up to a month to sign letters before they were sent out to GPs. This meant that letters were not sent in a timely manner.
- We found that the OPD was accurately monitoring patient pathways at the time of our inspection. The central booking service was consistently able to give patients appointments within NHS England and Clinical Commissioning Groups (CCGs) regulations 2012, meeting the 18-week targets in most specialities. We were able to see evidence of clear strategies to monitor and maintain systems to ensure that the trust met with these targets.
- The last published referral-to-treatment waiting times showed that the trust, on average, saw 96% of patients within 18 weeks (the NHS operating standard is 92%). A breakdown of these figures showed that some specialities performed better than this this, for example, in ophthalmology, where 99% of patients had completed their pathway within 18 weeks. Two specialities were performing slightly below target: neurology, where 91% of patients had completed their pathway within 18 weeks, and gastroenterology, where 85% of patients had completed their pathway within 18 weeks.
- The trust was consistently meeting with the two-week wait timescale for patients with urgent conditions, such as cancer and heart disease. They were consistently performing above the England average in this area. We were able to see evidence of clear strategies to monitor and maintain systems to ensure that the trust met with these targets.
- When the trust received a referral for an OPD appointment it was dealt with by the central bookings office. The team in this office had two separate processes for dealing with two-week and 18-week referrals. Two-week referrals were scanned onto a shared drive to allow consultants immediate access to these referrals. These referrals would be downloaded by the medical secretary and the patient booked into an urgent appointment. Multidisciplinary team (MDT) coordinators would be involved in this process to ensure that patents were given priority appointments.
- 61% of referrals to the trust were made through the 'choose and book' system. 18-week referrals were managed in paper format and were sorted and then sent to the relevant consultant for triaging based on clinical need. The consultant was given five days to triage and return the referral paperwork to central booking, who then sent a partial booking out to the patient. The patient would then ring into the team who would discuss an appointment date with them and book them into a clinic spot.
- The telephone system in the booking office was automated and staff were able to monitor the number of calls coming in and the length of time they were taking to answer calls. We saw from the statistics that staff were being constantly monitored by the department's manager. On the afternoon of our inspection, the team had already answered 329 calls that day with an average waiting time of one minute, 20 seconds to answer a call. The central booking office was open until 8pm, three nights a week to allow patients to call outside of working hours.
- The central booking team aimed to have patients booked for their initial appointment within six weeks of their referral to the service. The matron told us that this was to ensure that any follow-up diagnostic tests, or admission for inpatient treatment could be completed

within the 18-week timeframe. As a result of this, the trust had a better than England average for patients seen within six weeks of referral. On average, the trust saw half of their patients within five weeks of their referral. 19 out of 20 patients had treatment commenced in less than 17 weeks after referral. If the central booking team were concerned that a patient couldn't be found an appointment within their targets they would escalate this by following a 'breach' process. The patient would be referred to the Access, Booking and Choice waiting list management team (ABC coordinators). Each division had ABC coordinators, who managed potential waiting time breaches.

- Weekly Elective Performance Meetings chaired by the director of operations were held with representation from all divisions. During these meetings, teams discussed the management of waiting lists and made decisions around the extra clinics the trust would run in order to meet with the demands of each speciality.
- The trust's new to follow up ratio was consistently better than the national average. This meant that the trust was able to complete patient pathways within one appointment.
- Where follow-up appointments were needed, most specialities were able to book patients these appointments within the timescale that clinicians requested. Follow-up appointments were booked by the central booking teams in the case of ophthalmology, gastroenterology, rheumatology and urology. The computer system flagged up patients who required a follow-up appointment six weeks before the appointment was due. Automated letters were then sent to the patients, who were required to call the central booking office to arrange their appointment.
- If the central booking office was unable to book patients in for their follow-up appointment within the timeframe needed, they were required to follow a breach process. This meant that the team escalated the issue to the ABC coordinators.
- Some specialities booked their own follow-up appointments outside of the central booking team. This was completed by the medical secretaries for that speciality. Most medical secretaries told us that they were able to book follow-up appointments for patients within the timeframe required. However, the medical secretary for the renal service told us that they had problems booking follow-up appointments as there were not enough clinic spaces available. On the day of our inspection, they told us that their next available appointment was for February 2015, four months ahead. They told us that they had a follow up required in four weeks and six weeks that they were unable to book in. They said that if an appointment was an urgent appointment and the clinician agreed then the clinic would be overbooked.
- The chronic pain specialist nurse was the only specialist nurse employed by the trust in their speciality. They told us that they were unable to manage follow-up appointments in a timely manner. They showed us that, on the day of our inspection, they were booking follow-up appointments for patients in chronic pain for June 2015 (eight months ahead).
- The trust had a higher number of patients than the national average that did not attend their appointments (DNA). In order to manage this, the trust had made improvements to their appointment reminder service. Patients now received an interactive automated call seven days prior to their appointment, where they were able to change their appointment if they could no longer attend. Following this, patients received a text reminder two days before the appointment. This had improved on the number of DNAs from 10% down to 8%. To further improve this service, the trust was introducing more calls around the seven-day telephone call. This was to ensure that there were more opportunities for this call to be answered.
- The booking centre had just started a new initiative to allow a more interactive service with GPs. GPs were now offered a hotline number to call the centre directly. They were encouraged to ring this number with any high-priority queries around referrals. GPs were also encouraged to use a clinical queries email address to contact a relevant consultant or team with any clinical questions. Consultants, or their teams, were required to respond to the GP within 24 hours.
- The OPD audited the time that patients waited to be seen in clinic. The audit was repeated every quarter. We looked at the last two audits, which showed that patients were mostly seen within half an hour of their appointment time. In one audit 266 clinics were audited and of these 197 clinics finished within half an hour of their finish time with the majority of these finishing on time. 27 clinics finished within 31 to 60 minutes and 42

finished with a delay of over an hour. When we looked at the reason for delays most were because of consultation taking longer than expected, due to their complexity, or the wait for diagnostics.

- The OPD audited the number of clinics that were cancelled by the trust. Between September 2013 and September 2014, the OPD planned to run 67,064 routine clinics. Of these clinics, they had actually run 60,035. 5,427 clinics were cancelled with more than six weeks' notice, with 1,602 being cancelled with less than six weeks' notice. Staff and managers told us that the reasons for the majority of cancellations were for annual leave and training purposes. Where doctors did not give the required notice for cancelling clinics, we were told that this would be recorded on the incident reporting system and investigated.

Meeting people's individual needs

- The OPD was able to access translation services for patients. This was booked at the central booking office at the time that the patient's appointment was made.
- The OPD had folders for staff, which included information for assisting patients with a learning disability. The information included a variety of communication tools, along with information and spare copies of a hospital 'Health Passport'. Health Passports were completed at home and bought into hospital to give staff information on the best ways to care for the patient's individual needs.
- Staff ensured that patients who may be distressed or confused by the OPD environment were treated appropriately. Patients with a learning disability or diagnosis of dementia were moved to the front of the clinic list. Once in the department, they were given a private room and doctors came to see them in that room (where possible) to avoid them having too many moves around the department. The OPD staff liaised, where needed, with ambulance transport staff to ensure that this process ran smoothly.
- Central booking clerks told us that, where ladies required a female doctor to examine them due to cultural or religious preference, this request would always be respected. They said that ladies were always advised to ring on the day of their appointment to ensure that there had been no changes of clinician for the clinic, so that they could ensure that they were seen by a female doctor.
- Information leaflets were available in different languages upon request. The department was also able to access information leaflets in easy-to-read formats.
- 82% of OPD staff had received training in equality, diversity and human rights.

Learning from complaints and concerns

- We discussed complaints with the matron and OPD sisters, who all demonstrated a good understanding of the trust's procedures when dealing with formal complaints.
- We spoke with The Patient Advice and Liaison Service (PALS), who were able to provide us with a breakdown of concerns that had been raised regarding OPD. We looked at 11 concerns raised. With the exception of one (which was raised as a formal complaint) issues had been dealt with satisfactorily within the department.
- We saw evidence from staff meeting minutes that complaints were discussed with staff during these meetings. Staff that we spoke to were able tell us how complaints were discussed and the service improvement they made as a team.
- We were able to see examples on noticeboards around the department in which the OPD had listened to patient's feedback on patient surveys and had improved the service as a result. When we talked about complaints, staff referred to these examples.

Are outpatient and diagnostic imaging services well-led?

Requires improvement

Medical secretaries were consistently telling us that they were unable to meet the demands of their workloads. As a result, GP letters were not being sent within the five-day time frame as per the trust policy. None of the staff were aware of any plans to make improvements in this area.

Follow-up appointments were not being given to patients in a timely manner in the renal service. This could mean that patients were not being monitored safely where a medical need had been identified. We saw no clear strategies in place to improve the situation in the renal service, as the medical secretaries for this speciality told us that they had been struggling with capacity in the renal service for about six years. The service has attempted to

address the lack of capacity issues with the employment of an additional consultant which has alleviated pressure on the service by providing an additional 30 slots per week, but further capacity is still required.

The department relied on the goodwill of its staff in being flexible with their shifts and taking on extra hours. This meant that the way that the department was staffed might not be sustainable in the long term.

Most nursing staff in the department were complimentary about the support that they received from their managers.

Staff strived to ensure that patient experience in their department was the best that they were able to achieve. Staff were proud of their department and the care that they gave.

Vision and strategy for this service

- Trust-wide communications had been displayed in staff areas for staff to read.
- Staff were all able to discuss their roles and responsibilities confidently.

Governance, risk management and quality measurement

- Outpatients held a monthly clinical governance meeting and produced a monthly governance report, which was used to inform the trust's board and other stakeholders. During the meeting, all areas of governance were discussed and reported on, along with any learning or changes to the service. The agenda for this meeting included: incident reporting, complaints, training, human resources (HR) management, infection control, risks, health and safety, and audit results.
- The OPD used a number of tools to gather the data required to meet with the trust's governance arrangements. Incidents/accidents and near misses were recorded and investigated using the electronic recording system. The number of incidents and whether they were of a minor, moderate or serious nature were fed up to the trust board in the department's governance report.
- The governance report also outlined staff attendance at mandatory training, staff sickness levels, and compliance with the department's audits, such as the hand hygiene audit.
- The OPD matron was able to confidently describe what was on the department's risk register and how the department was mitigating risk.

Leadership of service

- Medical secretaries were consistently telling us that they were unable to meet the demands of their workloads. When medical secretaries were off on leave we were told that their work was not always covered. Although temporary staff were bought in to assist with the workload, at times, secretaries told us that this was not always done consistently and was not always successful, as staff were not trained and did not understand the complex medical terminology that was associated with each speciality.
- Follow-up appointments were not being given to patients in a timely manner in the renal service. This could mean that patients were not being monitored safely where a medical need had been identified. We saw no clear strategies in place to improve the situation in the renal service as the medical secretaries for this speciality told us that they had been struggling with capacity in the renal service for about six years.
- Following the inspection the provider informed us that the service has attempted to address the lack of capacity issues with the employment of an additional consultant. This has alleviated pressure on the service by providing an additional 30 slots per week, but further capacity is still required.
- Breaches in all other specialities were managed following clear procedures, which all of the staff we spoke with were aware of.
- The chronic pain specialist nurse was unable to manage follow-up appointments in a timely manner. The nurse was unable to provide us with any clear strategies to improve this service for patients.
- The management of two-week and 18-week referrals ensured that the trust consistently met with targets for waiting times. Weekly meetings were held with representatives from all specialities, where patients that could potentially breach waiting times would be discussed and acted upon.
- Managers were constantly working to utilise clinic spaces to assist with clearing waiting lists. Sisters explained to us how they saw cancelled clinics as an opportunity to clear other clinic waiting lists. All of the managers we spoke with were enthusiastic about their proactive management of clinic waiting lists.
- Staff were completing electronic records for incidents consistently. This meant that staff were able to learn from trends in incidents or use the data collected to effect positive changes to the service.

- Each OPD area held regular team meetings, where they discussed learning from complaints and incidents. They used this information to discuss and improve patient's experiences as a team.
- All of the nursing staff that we spoke with were able to describe their individual roles. This was backed up by competency assessments of staff that ensured that they both understood and were able to perform their roles to a required standard.
- All of the staff that we spoke to told us that they felt supported by the matron and sisters in the OPD. Nurse managers also told us that they were, in turn, supported by their own managers. Staff described the department's matron as "proactive" and "supportive".
- We saw staff interacting with their managers and saw that they did this in a relaxed and friendly way. The managers were seen supporting more junior members of staff when it was required.
- Staff we spoke with told us that they felt supported by their managers, particularly during times when the department was busy. One member of staff described an incident to us where their manager had supported them when a patient had become verbally aggressive.

Culture within the service

- Throughout our inspection, staff in the OPD were welcoming and happy to interact with us and answer our questions. There was an obvious sense of pride from staff about their department and they were keen to tell us about things that they were doing to improve patient experience.
- All of the staff we spoke with were able to discuss the trust's CARES initiative confidently.
- Throughout our inspection, staff were consistently driving the message that their main aim was to make the patients' experience through their service as good as it could be. This philosophy was evident in the interactions we witnessed between staff and between staff and patients.

Public and staff engagement

- The OPD ran a quarterly patient satisfaction survey that patients were encouraged to complete, either on an electronic tablet or on paper. Each department was required to complete a set number of surveys with patients in order to meet their target.
- The OPD had been piloting an NHS Friends and Family Test across nine of its clinics. As the pilot was reaching its conclusion, NHS Friends and Family Tests were about to be rolled out across all clinics. The results of the NHS Friends and Family Tests and patient surveys were displayed in clinic areas.
- Noticeboards in OPD areas showed visitors and patients how their comments and complaints had been used by the OPD to improve patients' experience of the service.

Innovation, improvement and sustainability

- The department held regular staff meetings, where important messages were shared with staff. The staff that we spoke with told us that if they felt they could improve the department they would raise this either during these meetings or directly with their department manager.
- The department relied on the goodwill of its staff in being flexible with their shifts and taking on extra hours. This meant that, the way that the department was staffed might not be sustainable in the long term.

Outstanding practice and areas for improvement

Outstanding practice

- The effective management of 18 week referral to treatment times for patients.
- The specialist care for children with diabetes, specifically the outreach work into schools.
- A maternity triage care bundle to promote consistency of care provided for women.
- Announced and unannounced "skills drills" training to rehearse obstetric emergencies.
- Trainee doctors commented very positively on the support and mentorship they received while working at the trust.
- Good multidisciplinary team working to support one stop outpatient clinics.
- The critical care unit had a physiotherapy presence seven days a week, and undertook ward rounds each day, as well as being available on call.
- The trust had a proactive specialist nurse for organ donation.

Areas for improvement

Action the hospital MUST take to improve

- Make sure it complies with infection prevention and control standards and that it monitors cleanliness against national standards.
- Assure itself that the ventilation of all theatres meets required standards.
- Manage the risks associated with the numerous staffing establishment shortages across the trust.
- Make sure that staff are appropriately trained in safeguarding both adults and children, and that the trust regularly monitors and assesses the completion of actions agreed at weekly 'safety net' meetings.
- Make sure that all staff understand their responsibilities in relation to the trust's systems and processes that exist to safeguard children.
- Make sure staff are trained and understand their responsibilities in relation to the Mental Capacity Act and Deprivation of Liberty Safeguards.
- Make sure that the use of keypads on wards does not unlawfully restrict patients' liberty.
- Make sure that all staff receive the full suite of mandatory training that is required to ensure patient safety.
- Make sure that there are adequate numbers of paediatric staff trained in Advanced Paediatric Life Support as per the Royal College of Nursing's recommended standard.
- Make sure of the effective operation of systems to enable the trust to identify, assess and manage risks relating to the health, welfare and safety of patients.
- Make sure that local leaders are held accountable if they do not routinely and accurately complete required audits.
- Make sure that trust premises are secure and that maternity and children's areas and wards cannot be accessed by the public without staff knowledge and appropriate challenge when necessary.
- Make sure patients are protected against the risks associated with the unsafe use and management of medicines.
- Make sure patients and visitors are protected against the risks associated with unsafe or unsuitable premises.
- Make sure that equipment is properly maintained and suitable for its purpose and that out of date single use equipment is disposed of appropriately.
- Make sure that equipment is available in sufficient quantities in order to ensure the safety of patients and to meet their assessed needs.
- Make sure that records are accurately and appropriately maintained, are kept securely and can be located promptly when required.
- Make sure that early warning system documentation is appropriately maintained and that all staff react appropriately to triggers and prompts.

Outstanding practice and areas for improvement

Action the hospital SHOULD take to improve

- Review the process for admitting patients to wards from the accident and emergency department to make sure the process is effectively managed and that unnecessary delays in transferring patients are not occurring.
- Review the resourcing of medical secretaries to make sure they can meet patient need and the trust's own targets for sending GP letters.
- Ensure there is a fixed rota for consultant cover out-of-hours for the critical care unit.
- Consider providing support from a Practice Nurse Educator for critical care nursing staff.
- Consider contributing to ICNARC data collection.
- Confirm the trust's permanent bed capacity and an accurate base staffing establishment figure the trust projects it needs to deliver safe and effective care for this number of beds.
- Engage with local end of life care leadership to establish the trust's strategy for the service.
- Make sure that appropriate translation services are available and are being utilised to meet patient need.