Care Quality Commission

West Middlesex University Hospital NHS Trust

West Middlesex University Hospital NHS Trust

Quality Report

Twickenham Road
Isleworth
Middlesex
TW7 6AF
Tel: 020 8560 2121
Website: www.wmuh.nhs.uk

Date of inspection visit: 25–28 November 2014
Date of publication: 07/04/2015

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

Summary of findings

Letter from the Chief Inspector of Hospitals

West Middlesex University Hospital is the main acute hospital for the West Middlesex University Hospital NHS Trust, which provides acute medical services to a population of around 400,000 people across the London Boroughs of Hounslow and Richmond on Thames and surrounding areas.

Following the board's decision that this trust would not meet the requirements for Foundation Trust status, it has been in negotiations to merge with another NHS trust. Following our inspection, it was announced on 19 December 2014 that the merger with Chelsea and Westminster NHS Foundation Trust had been approved by the Competition and Markets Authority.

The trust is planning for an increase in emergency and maternity attendances that will result from The London North West Strategy, "Shaping a Healthier Future".

We carried out this comprehensive inspection as part of our overall inspection programme of NHS acute trusts. We undertook an announced inspection of the trust between 25 and 29 November and unannounced inspections on 9 and 13 December.

We inspected all the main departments of the hospital: Urgent and emergency services (A&E),medical care,surgery,critical care,maternity and gynaecology,services for children and young people,end of life care, and outpatient and diagnostic imagery.

Overall this hospital requires improvement.

We rated the hospital good overall in the following departments: medical care,critical care and maternity and gynaecology. However, our inspection results rated the following services as requiring improvement: urgent and emergency services,surgery,services for children and young people,end of life care, and outpatients and diagnostic imaging.

While we rated the hospital as good overall in caring,it requires improvement overall in providing safe care,being responsive to patients' needs and being well-led. We rated the hospital overall as inadequate in providing effective care.

Our key findings were as follows:

- Most patient, carer and patient relative feedback was positive in relation to the care being provided by the hospital.
- We saw many examples in most areas of the hospital of staff giving treatment in a caring and compassionate way.
- We found care being delivered in a supportive atmosphere.
- Critical care wards were consistently good in relation to safe and effective treatment which was responsive to patient needs, delivered with compassion and in a well-led culture.
- The physical environment in the hospital was well maintained as well as clean and hygienic.
- The urgent and emergency care department had a calm and well managed response to heavy emergency demand on the Wednesday evening during our inspection visit.
- Uncertainty around the merger with another trust had resulted in a number of interim appointments in clincal and managerial areas. The trust had recently started to appoint to permanent posts notably Director of Nursing.
- There was widespread access to the Datix incident reporting system to allow staff to report incidents. However, feedback and learning to staff arising from those incidents was mixed in effectiveness.
- There was insufficient consultant support in palliative care and the trust overall had not given sufficient focus on end of life care.There were mixed levels of understanding of the compassionate care pathway.
- There were concerns about the leadership in the Special Care Baby Unit (SBCU) and this had an adverse effect on the performance overall of services to children and young people.
- The hospital has a limited acute oncology service.

Summary of findings

- The trust did not have a robust document and policy management process. We found several examples of out of date policies in use on the wards.
- Ultrasound capacity in the early pregnancy unit was insufficient to meet demand.

We saw several areas of outstanding practice including:

We saw several areas of outstanding practice including:

- The A&E department had a calm and well-managed response to very heavy emergency demand on the Wednesday evening of our inspection visit. Management support was also well considered, calm and effective.
- We found the care and support given by the mortuary staff and patient affairs office to relatives after the death of their family member was exemplary.
- The innovative 'heads-up' structured approach to handover in medicine

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

Importantly, the trust must:

Address the midwife/mother ratio both in terms of immediate levels of care and the strategic planning for expansion of obstetric services.

- Review and act upon consultant and nursing staffing levels in Emergency Services
- Review the processes for the management of policies and procedures to ensure that staff has access to the most up to date versions.
- Review its provision of End of Life services; its palliative care staffing levels and support of end of life care on the wards.
- Ensure full completion of DNACPR forms
- In medicine, address the lack of an acute oncology service
- In surgery, improve the frequency of consultant ward rounds.
- Ensure full completion of WHO Checklists for surgery
- Remove the practice of unverified consultant patient discharge letters
- Improve leadership and effectiveness in the SBCU
- Address the issue of late availability of TTA medicines leading to late discharge or patients returning to collect them.

In addition the trust should:

- Further develop it's strategies for ensuring that the organisation is learning from incidents and issues.
- Continue to clarify its strategic intent, stabilise leadership and continue to engage its workforce in planning for change.
- Review its pharmacy services to be more responsive to the needs of patients
- The trust should ensure that the room in the A&E department designated for the interview of patients presenting with mental ill health has a suitable design and layout to minimise the risk of avoidable harm and promote the safety of people using it.
- The trust should review the arrangements for monitoring patients in the A&E department to ensure clear protocols are consistently used so that changes in patients' condition are detected in a timely way to promote their health.
- The trust should review the number and skill mix of nurses on duty in the A&E department to reflect Royal College of Nursing Baseline Emergency Staffing Tool (BEST) recommendations to ensure patients' welfare and safety are promoted and their individual needs are met.
- The trust should review the number of consultant EM doctors employed in the A&E to reflect the College of Emergency Medicine (CEM) recommendations.
- The trust should respond to the outcome of their CEM audits to improve outcomes for patients using the service.

Summary of findings

- The trust should review the arrangements for monitoring pain experienced by patients in the A&E to make sure people have effective pain relief.
- The trust should review the arrangements for providing people with food and drink and assessing their risk of poor nutrition so people's nutrition and hydration needs are met.
- The trust should review their arrangements for assessing and recording the mental capacity of patients in the A&E to demonstrate that care and treatment is delivered in patients' best interests.
- The trust should make arrangements to ensure contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- The trust should review some areas of the environment in A&E with regard to the lack of visibility of patients in the waiting area and arrangements for supporting people's privacy at the reception, the observation ward and the resuscitation area.
- The trust should review the provision of written information to other languages and formats to that it is accessible to people with language or other communication difficulties.
- The trust should review the way it considers the needs of people living with dementia when they are in the A&E department.
- The trust should review their management of patient flow in the A&E department so patients are discharged in a timely way or transferred to areas treating their specialty.
- The trust should review the risk register in the A&E to make sure all identified risks are included and action is taken to mitigate.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Our judgements about each of the main services

Service	Rating	Why have we given this rating?
Urgent and emergency services	Requires improvement 	- The trust did not meet The College of Emergency Medicine (CEM) recommendation that an A&E department should have enough consultants to provide cover 16 hours a day, 7 days a week. - Nurse staffing levels did not consistently meet the Royal College of Nursing Baseline Emergency Staffing Tool (BEST) recommendations, which compromises patient safety. Tools for monitoring patient's condition were not consistently used, which increases the risk of undetected deterioration in patient's conditions. - The department participated in clinical audits, but the results were not used effectively to improve patient outcomes. People's nutrition and hydration needs may not be met because the arrangements for providing people with food and drink and assessing their risk of poor nutrition were not robust. - There was a lack of consistency in how people's mental capacity is assessed and recorded. - The service did not fully take into account needs of the local multicultural population. Services were not delivered in a way that focuses on people's holistic needs, such as those living with dementia. - The facilities and premises did not always promote people's privacy, dignity and confidentiality. - Patient flow was poor and waiting times were above the national average due to capacity constraints. - The systems for identifying and managing risk in the A&E need to be strengthened to support the delivery of safe and effective care.
Medical care	Good 	- Medical wards provided safe patient care, which was in line with national best practice guidelines. Clinical audit was being undertaken and there was good participation in national and local audit with good outcomes demonstrated for patients. - Most patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them.

Summary of findings

			- The medical division was well led; managers had a clear understanding of the key risks and issues in their area. Ward staff felt well supported by their ward sisters and matrons. - However, staff were not always sufficiently trained to support patients who were living with dementia or those living with a learning disability.
Surgery	**Requires improvement**		- The department provided safe care and patients spoke positively about their treatment. There were enough staff on wards and in theatres and staff received appropriate training. - Theatres had systems in place to maintain patients' safety including team briefs and the World Health Organisation (WHO) theatre checklist. - However,while there was evidence of good outcomes for many patients who underwent surgery, the hospital was not meeting the needs of some fracture patients as effectively as other hospitals, for example in hip treatment. - There were limited services out of hours and at weekends. - Most patients considered the surgical services were responsive to their needs. However, there was no shared vision for surgery at the hospital and a tendency for staff in sub specialities to work in silos, unaware of concerns in other sub specialities that others had. - Medical staff did not seem well engaged with management issues. However, at ward level we saw good leadership and enthusiastic staff.
Critical care	**Good**		- Patients and relatives spoke highly of the care and treatment they received in the Intensive Treatment Unit and High Dependency Unit. - The critical care unit (CCU) operated a model of care in line with guidance from the Intensive Care Society. Multidisciplinary (MDT) team working ensured patients received an holistic approach to care and treatment. - Care and treatment was delivered by trained and experienced nursing staff who worked in dedicated teams with a clear reporting structure and staff support. - The CCU participated in recommended national audits and local audits.There was a clear incident reporting system and staff felt able to report incidents and raise any concerns.

Summary of findings

Maternity and gynaecology

Good

- The maternity and gynaecology services had reported three never events between April 2013 and May 2014 , two of which related to retained swabs and one which related to a retained tampon. There had been a serious incident in September 2014 which had resulted in a patient being transferred from the maternity unit to the intensive treatment unit (ITU).These incidents had been thoroughly investigated and learning obtained from them.
- The service used the NHS safety thermometer to support the provision of safe care for women.
- Consultants were on duty seven days a week, supported by a team of registrars and junior doctors who were on site out of hours. Both doctors and midwives considered they worked in supportive teams.
- The service used a modified early warning score chart to measure patients' conditions and to determine when prompt treatment was required. Staff knew how to raise concerns and how to make safeguarding referrals.
- The wards were clean and uncluttered. Equipment was appropriately checked and cleaned and had been serviced regularly.
- There was effective multidisciplinary working within the maternity department, with other services within the trust and with external organisations.
- Midwives felt supported by their line managers and by the supervisors of midwives. Junior doctors at all levels felt supported by consultants and registrars However, there was a shortage in the number of midwives employed and the staffing level and skill mix of nursing staff in the early pregnancy unit also raised concerns.
- Women had access to a full range of options for birth, subject to an appropriate risk assessment.
- Mothers and their partners we spoke with were generally complimentary about the service and the care they had received before, during and after the birth of their baby.

Services for children and young people

Requires improvement

- Overall we found many aspects of the service were positive, but some areas including infection prevention and control and feedback and learning from incidents required improvement.

Summary of findings

- Good arrangements for safeguarding children and babies were in place and staff were aware of their responsibilities. There was consultant cover seven days per week and the trust was recruiting additional consultants.
- Staff used evidence based guidelines and audits and peer reviews were taking place but feedback and learning from incidents, particularly on the SCBU needed to be improved.
- Children and parents we spoke with felt staff involved them in discussions and decisions about their care. On the children's ward formal feedback was sought from parents and children. However, less formal feedback was obtained on the SBCU.
- Leadership in the main children's services was good but changes and gaps in the leadership on the SCBU had impacted on the motivation and morale of staff.

End of life care

Requires improvement

- The specialist palliative care service (SPCT) at West Middlesex hospital was smaller than most hospitals of an equivalent size.The trust was providing 1/6th of the required specialist palliative care consultant cover recommended by national commissioning guidelines and 1.1 WTE consultant nurse specialist (CNS) cover against a recommended level of 1.6 WTE.
- There was no formal CNS cover for absences.
- There was no in-house out of hours consultant cover. This was provided by a local hospice.
- Staff told us that there was no trust End of Life Care(EOLC) policy or strategy. Staff reported there had been very little consistent senior management engagement.
- Staff were unsure who led on EoLC at Trust board level, although the medical director had recently been told that they had been given this board responsibility.
- We were told of future aspirations to bring patients' EoLC to the forefront of staff minds through training and to develop integrated pathways that involved community services such as GPs and nursing homes. However the Specialist Palliative Care Team (SPCT)had little time to develop this or provide training to staff as their working day only allowed time for clinical support.

Summary of findings

- While most hospital staff were complimentary about the support they received from the existing clinical nurse specialists (CNS), the Specialist Palliative Care Team did not have the resources to provide support to patients seven days a week.
- Where the service had been involved in patients' EoLC we saw appropriate recognition that the patient was dying, escalation procedures followed by details of discussions and advice were documented in detail. However we found there was a mixed response to how patients reaching the end of their life were cared for by nursing staff on the wards.
- Staff did not always recognise patients were in the stages of dying, and therefore escalation and appropriate support was not always given in a timely manner.
- There were weekly SPCT MDT meetings. However, meeting notes showed that these had only taken place on 30 out of the 52 weeks throughout the year.
- A majority of the 'do not attempt cardio pulmonary resuscitation' (DNACPR) forms we viewed had been completed in full and appropriately. However documentation of mental capacity assessments was inconsistent.
- There were limited governance systems although some audits had taken place.
- There was no system to identify dying patients who were not already under the SPCT. Therefore there were patients and families not benefitting from specialist palliative care input and support when they could be.
- The care and support given to relatives after the death of their family member by the mortuary staff and patient affairs office to be exemplary. The Chaplaincy had a good working relationship with the SPCT in providing emotional and spiritual support to patients, relatives, friends and staff.

Outpatients and diagnostic imaging

Requires improvement

- Up to date policies and procedures were in place to support a safe service for patients using the outpatients and diagnostic imaging department.
- There were sufficient staff to run all the services. Incidents related to safeguarding were appropriately recorded and actions were taken in order to address them.

Summary of findings

- Staff were caring and treated patients with dignity and respect.
- Medicines were securely stored in a locked medicines cupboard, and other medicines that require refrigeration were kept at recommended temperatures.
- The outpatient and diagnostic imaging areas were clean and equipment was maintained. However in some clinics cleaning schedule records were eihter poorly completed or not completed at all.
- Not all clinics ran on time and there was a need to reduce the number of cancelled clinics.
- There was active patient involvement to improve services. People who attended the outpatient department and diagnostic imaging department were positive in their comments about their care and treatment.

West Middlesex University Hospital NHS Trust

Detailed findings

Services we looked at

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

Detailed findings

Contents

Background to West Middlesex University Hospital NHS Trust

The trust provides services from one main site at West Middlesex University Hospital, which is a small acute hospital in Isleworth, west London. The hospital serves a local population of around 400,000 people in the London boroughs of Hounslow and Richmond on Thames and neighbouring areas. The main commissioners of acute services are the clinical commissioning groups (CCGs) for Hounslow and Richmond.

The 2011 Census of England and Wales shows that half of Hounslow's population was from an ethnic minority group. The largest ethnic minority group was Indian, which made up 19% of local residents, while other Asian made up 8% of the population and Pakistani 5%. The census for Richmond showed a population of around 187,000, which is small for a London borough. Richmond is also one of the least ethnically diverse boroughs in the capital, and has a non-white population of 14%.

Deprivation

Hounslow's deprivation score is 156/326, and for Richmond it is 266/ 326 (the lower scores reflect higher levels of deprivation, and are based on a comparison between all 326 local authority areas in England). Hounslow is the ninth largest borough in London, while Richmond is the eighth largest by area and the least deprived.

The health of people in Hounslow is varied compared with the England average. Deprivation is lower than average, life expectancy for both men and women similar to the England average, but 12,400 children live in poverty. The life expectancy for men and women living in Richmond is higher than the England average, and deprivation lower than the England average.

Our inspection team

Our inspection team was led by:

Chair: Dr Nick Bishop MB BS MRCS FRCP FRCR; CQC, National Professional Adviser for Medical Services

Head of Hospital Inspections: Alan Thorne, Care Quality Commission (CQC)

Inspection Manager: Robert Throw, Care Quality Commission (CQC)

The team included CQC managers and inspectors, analysts and planners plus a variety of specialists including a former NHS chief executive ; a head of clinical services and quality; a safeguarding clinical lead; haematology physician; clinical oncologist ; oral and maxillofacial surgeon; clinical fellow in emergency medicine; consultant in obstetrics and gynaecology; critical care consultant; medical director; junior doctor; paediatric and adult nurse; head of outpatients; infection

Detailed findings

prevention and control nurse; pharmacist; A&E nurse; head of midwifery; critical care senior nurse; neo natal nurse practitioner; and student nurse. We also had experts by experience who were service users and patient representatives.

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

The announced inspection visit took place between 25 and 28 November 2014, with subsequent unannounced inspection visits on 9 and 13 December 2014.

Before the inspection visit we reviewed a range of information we held, and asked other organisations to share what they knew about the trust such as local Healthwatch organisations and the Hounslow and Richmond CCGs. We also held a listening event on 20 November 2014 when members of the public shared their views and experiences of West Middlesex University Hospital.

During our inspection we held focus groups with a range of hospital staff that included: nurses; doctors; consultants; allied health professionals; and support workers. We spoke with patients and staff from all areas of the trust, including: wards; surgical theatres; outpatient departments; maternity; and A&E. We also spoke with hospital managers, members of the trust executive team and non-executive directors. We observed how people were being cared for and talked with their carer's and family members. We reviewed patients' personal care or treatment records, and inspected medicine management records and drug charts. We looked at trust policies and assessed treatment against national guidelines.

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 West Middlesex University Hospital NHS Trust.

Facts and data about West Middlesex University Hospital NHS Trust

The trust provides services from one main site at West Middlesex University Hospital, which is a small acute hospital in Isleworth, west London. The hospital serves a local population of around 400,000 people in the London boroughs of Hounslow and Richmond on Thames and neighbouring areas. The main commissioners of acute services are the clinical commissioning groups (CCGs) for Hounslow and Richmond.

- The trust has 335 general and acute beds, 49 maternity beds, 13 critical care. The Trust employs 1945 staff as at Oct 14, 363 medical, 764 nursing, 218 other plus contracted out services through the PFI. It has a turnover of around £155m and is running a planned deficit of £4.9 m
- The workforce was supported by 15.9% bank and agency staff against a national average of 6%.
- The trust had 46,000 inpatient attendances, 246,000 outpatients and 137,000 emergency attendances (this figure includes 70,000 attendances at the community managed urgent care centre that is co-located with A/E)
- The trust reported four never events between August 2013 and June 2014. Three of the four Never Events took place in the maternity department in August 2013, March and May 2014. Two Never Events were related to retained swabs and one was related to a retained tampon. The fourth Never Event took place in August 2013 in general medicine, and involved a misplaced nasogastric tube

Detailed findings

- Between April 2013 and May 2014 the trust reported 96 Serious Incidents. They consisted of 43 grade 3 pressure ulcers, 15 unexpected readmissions to neonatal care unit (NICU), 9 ambulance delays, 4 communicable diseases and 25 others.
- There were a total of 2,361 incidents reported between April 2013 and May 2014. They included: 10 deaths, 23 severe harm, 285 moderate harm, 612 low harm and 1431 no harm.

There were 87% NRLS incidents reported with no or low harm. The trust also reported fewer incidents than the England average. CQC analysis indicates that this is statistically lower and is therefore a risk.

Our ratings for this hospital

Our ratings for this hospital are:

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

Notes

Urgent and emergency services

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

Information about the service

The accident and emergency (A&E) department is also known as the emergency department (ED). It is a designated trauma unit.

The department saw 57,852 patients between April 2013 and March 2014. Of the patients seen 79% were aged over 17 and 21% of patients were aged 0 to 17-years-old. Between April 2014 and September 2014 the department saw 26,053 patients.

A&E is divided into areas depending on how serious the symptoms of patients. The resuscitation area has four bays including one designated bay for paediatrics. There are 10 cubicles/rooms in majors A, and 9 cubicles/rooms and one chair space in majors B. In addition, there is an observation ward with four beds and eight chair spaces. The paediatric area has four rooms.

There is a room near reception to assess and triage patients who did not come into A&E by ambulance patients, and additional rooms designated for a plaster room, eye room and minor ops.

We visited the A&E over three weekdays during our announced inspection. We observed care and treatment and looked at patients' records. We spoke with 31 members of staff that included: nurses; consultants; doctors; receptionists; managers; support staff; and ambulance crews. We also spoke with 19 patients and seven relatives who were using the service at the time of our inspection. We received comments from our listening events and from people who contacted us to tell us about their experiences. We also used information provided by the organisation and information we requested.

Urgent and emergency services

Summary of findings

The A&E department requires improvement to ensure that patients are protected from avoidable harm.

Medicines were not always stored securely or checked regularly, which increases the risk of medicine misuse. The trust did not meet the CEM recommendation that an A&E department should have enough consultants to provide cover 16 hours-a-day, seven days-a-week. This compromises senior clinical decision-making, which could negatively impact the patient's care pathway care. Nurse staffing levels did not meet the Royal College of Nursing (RCN) Baseline Emergency Staffing Tool (BEST) recommendations consistently, which compromises patient safety. Tools for monitoring patient's condition were not always used, which increases the risk of undetected deterioration in a patient's conditions.

The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand sanitising gel. The bare below the elbows policy was observed by all staff. Medicine administration records were completed accurately in the patient records we looked at.

Incidents

- There was limited evidence that trends or lessons learned from incident reporting were shared effectively with department staff. We spoke with medical, nursing and allied health professionals who told us they knew how to report incidents and they were given feedback about the outcome if they requested it. Staff said they "occasionally" use the reporting system. Nursing staff told us they were more likely to use the department's hourly report system that captured events (such as overcrowding, patients with challenging behaviours, staff shortages) in real time and was escalated to senior managers. Junior and middle grade doctors said they rarely used the reporting system.
- We asked senior nursing management to demonstrate the reporting system so we could look at a summary of current and outstanding incident reports that they were responsible for reviewing, but they did not have access to the system over the two days of our inspection. There were no other systems in the department such as hard copies or summaries that captured recent trends or identified the safety priorities raised as a result of incident reporting. A further two senior nurses were unable to access the system to demonstrate it to us because their password had expired, which meant they were locked out of the system.
- A&E reported 13 serious incidents between April 2013 and October 2014. All serious incidents resulted in a root cause analysis (RCA), and action plans were put in place to reduce the likelihood of similar events occurring in the future.
- A serious incident was reported in December 2013 when a patient brought into A&E by ambulance and placed in the waiting room was not seen. The patient was later found collapsed on a chair in the A&E waiting room. The patient was transferred immediately into the resuscitation area and found to have a head injury. RCA concluded the patient was insufficiently observed in the waiting room while waiting to be seen. Actions planned in response included: developing clear pathways for the discharge of homeless patients out-of-hours; training provision around the management of frequent attenders with psycho-social, drug and alcohol dependencies; and ensuring patients are seen in a timely way after being accepted by a clinician.
- A further serious incident was reported in September 2014 when a patient came to A&E with vaginal bleeding following a caesarean section three weeks earlier.
- There were 11 of the 13 incidents that related to breaches of ambulance handover times, none of which resulted in actual patient harm.
- Mortality and morbidity (M&M) meetings were held regularly to review the care of patients who had had complications or an unexpected outcome. Learning was shared and it informed future practice. We looked at minutes of the last three monthly M&M meetings that identified issues about the use of DNA CPR orders in the community. Attendance was limited to A&E medical and nursing staff.

Urgent and emergency services

Cleanliness, infection control and hygiene

- A labelling system was used to indicate that an item had been cleaned and was ready for use. The equipment we looked at was clean.
- The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand sanitising gel. The bare below the elbows policy was observed by all staff.
- We observed that staff complied with the trust policies for infection prevention and control (IPC). This included wearing the correct personal protective equipment (PPE), such as gloves and aprons.
- Side rooms were available for patients who might have a possible cross-infection risk.
- The department was clean and tidy. We saw support staff cleaning the department throughout the day in a methodical and unobtrusive way. Cleaning staff we spoke with knew the areas they were responsible for cleaning, but were unable to provide us with written cleaning schedules.
- Of the staff in the trust's medicine division, which includes A&E, 89% had attended infection control training against a trust target of 95%.
- Between April 2014 and October 2014 A&E reported the following avoidable infections:
  - One incident of MRSA
  - No incidence of Clostridium difficile (C. difficile)
  - Six incidents of MSSA (methicillin-sensitive staphylococcus aureus)
  - 66 incidents of E. coli.
- We spoke with the senior band 7 nurse with a designated responsibility in the department for infection control audits. Audits undertaken show good staff compliance with hand washing and practical infection control techniques. For example, it was used during insertion of peripheral intravenous cannulae and urinary catheters. However, audits demonstrated poor recording of infection control measures in patients' notes.

Environment and equipment

- There was sufficient seating in the waiting room and reception staff had a direct line of sight of most of the area. Vision from the reception area was obstructed by a curved wall in the waiting room. Reception told us there had been a violent incident between patients that they had not seen because of the design of the wall.
- There was a small area to accommodate a trolley for the handover of patients arriving by ambulance.
- There was one triage room near the reception area. Nursing staff told us they sometimes used a cubicle in Majors B if a lot of patients were waiting.
- The resuscitation area had four bays that included a bay designated for the resuscitation of children, which contained a wide range of equipment for patients of all ages. Equipment was clean, regularly checked and ready for use.
- The department had two majors areas. Majors A had eight cubicles and two side rooms. This area was used 24 hours-a-day. Majors B had eight cubicles, one side room used as the eye room and one chair. Staff told us this area was used between 11am and 2am daily and extra nursing staff were rostered to cover the area during these times. Majors B was used outside of these hours when the department required extra capacity.
- There were two further designated rooms for plaster and minor ops.
- There was no separate children's A&E, but provision had been made so children were accommodated in a dedicated area of the department with four individual rooms. There was a paediatric workstation for nurses and medical staff. The separate waiting room for children inside the department had observation windows allowing staff to monitor the area. The children's area was accessible by adult patients and visitors because it was a thoroughfare to exits and other parts of A&E. This compromised the safety of children attending the department and was included in the trust's risk register.
- The six areas of the department were geographically separated from each other by corridors: triage; resuscitation; majors A; majors B; observation ward; and paediatrics.
- A room was available for private and quiet discussions with relatives and an adjoining room was available where relatives could spend time with their loved one in the event of their death.

Urgent and emergency services

- Electronic locks maintained a secure environment. There was a facility to lock down A&E in the event of an untoward incident.
- Each bed space in the resuscitation area was designed and configured in exactly the same way. This allowed staff working in that area to be familiar with the bed space, which led to improved working during trauma and resuscitation events.
- A room was designated for interviewing patients presenting with mental ill health. The room had two exits, but we identified ligature points and the storage of portable gas cylinders for use as a potential weapon. This put people at risk of avoidable harm. This was included on the trust's risk register.
- The x-ray department and CT scanning facilities were adjacent to the A&E departments and were easily accessible.

Medicines

- We saw that locks were installed on all store rooms, cupboards and fridges containing medicines and intravenous (IV) fluids. Keys were held by nursing staff.
- On two occasions we found the medicine fridge in the resuscitation area unlocked while no staff were present. Medicine fridges in drug storage rooms were unlocked, but the storeroom door was locked. Fridge temperatures were not regularly recorded, which means staff cannot demonstrate that medicines have been stored at the correct temperature to maintain their effectiveness.
- We saw several practices that increase the risk of medicine error and compromise patient safety. We observed a nurse draw up a syringe from an ampoule and leave it unattended and unlabelled while they went to complete a task in another part of the department before returning to the syringe to complete the labelling. We also observed unlabelled syringes containing clear fluids left on a worktop in resuscitation. There was very limited workspace for preparing medicines in the resuscitation area, which increases the risk of error and contamination. We found nebules of medication for use in nebulisers loose in paediatric cubicles, and bottles of saline and other solutions on shelves on the plaster room and minor ops room, which means they were accessible to the public and children in the department.
- The A&E department was in the trust's top three areas for reporting medicine errors. In the last three-month period the departmentreported 411 medicine error incidents.
- We found that controlled drugs (CD) were regularly checked by staff working in the department. We audited some of the contents of the CD cupboard against the CD register and found it was correct.
- Medicine administration records were completed accurately in the patient records we looked at.
- Of staff in the trust's medicine division, which includes A&E, 84% had completed medicines management training against a trust target of 80%.

Records

- A paper record was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- An electronic patient system ran alongside paper records and allowed staff to track patients' movement through the department and to highlight any delays.
- Specific pathway documentation was available for patients presenting with specific conditions, for example a fractured neck of femur. The documents were clear and easy to follow. There was space to record appropriate assessment that included: assessment of risks; investigations; observations; advice and treatment; and a discharge plan.
- We looked at the care records of 10 patients and found they were completed.
- Of staff in the trust's medicine division, which includes A&E, 85% had completed information governance training against a trust target of 90%.

Safeguarding

- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.

Urgent and emergency services

- Staff had access to patients' previous attendance history and to regularly updated lists of children identified at risk in their home environment. In addition, children's notes were reviewed by a health visitor to screen for children at risk of harm.
- Of staff in the trust's medicine division, which includes A&E, 89% had completed level one safeguarding adults training against a trust target of 80%. For level two safeguarding adults training 50% of staff in the trust's medicine division, which includes A&E, had completed it against a trust target of 80%.
- Of A&E medical staff 44% had completed training in safeguarding children at level two (ST2) and three (ST3). We were told that trust training records do not distinguish between ST1-3 and ST4 and above. This means the trust cannot demonstrate it meets the recommendation that all senior emergency medicine (EM) doctors (ST4 and above) are trained in safeguarding children at level three as a minimum.
- Of A&E nursing staff 78% had completed training in safeguarding children at level three, and 80% had completed training at level two.

Mandatory training

- Compliance with statutory and mandatory training was generally good. For example, 83% of staff in the trust's medicine division, which includes A&E, had completed fire training, 87% had completed health, safety and risk management training, and 84% had completed patient handling training against a trust target of 95%.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
- Patients arriving in an ambulance were brought into an area adjacent to the workstation in majors A where the designated nurse in charge took a handover from the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated.
- In the 12 months up to August 2014 the trust's A&E scorecard showed the average arrival to assessment time was 16 minutes for patients arriving by ambulance, which was close to the target of 15 minutes.
- NHS England winter pressures daily situation reports (SITREP) data for the trust between November 2013 and March 2014 showed there were 511 occurrences when ambulances waited more than 30 minutes to hand over. This was better than other trusts nationally.
- There was an over reliance on clinical observation and judgement for the monitoring and escalation of deteriorating patients. Early warning scoring tools for adults and children (NEWS/PEWS) were not used in the department, although they were used on wards in the trust. This has been recognised by the recently appointed service lead for nurses, and training was planned and had started to be implemented to embed NEWS/PEWS in A&E. Records we looked at showed observations of patients' vital signs were repeated and recorded for some patients, but there was no specific protocol for frequency or escalation because the EWS tool was not used. This put patients at risk because of the failure to detect deterioration in their condition.
- For patients walking in to the department, or for people brought into A&E by friends, a streaming system is used. This is provided by the urgent care centre (UCC) and run by Hounslow Richmond Community Health. The UCC was adjacent to the A&E department and shared the large waiting area. We spent some time at the UCC reception and observed an effective streaming process.
- The first point of contact for self-presenting patients was the UCC receptionist, who recorded their details and a brief description of their reason for attending the department. The patient was then immediately passed to a UCC nurse who directed the patient to the UCC or to A&E. A clear protocol was in place to identify patients for care in either UCC or A&E. The streaming nurse gave patients for A&E a card that they took to the A&E reception at the other end of the waiting room. The UCC and A&E shared patients' details electronically.
- Patients were called into the triage room for assessment by a nurse. The A&E used the Manchester

triage guidelines to determine the severity of the patient's injury or illness. This was reflected on the department's Symphony system, the electronic A&E patient booking system. But, triage priority was not recorded on the patients' CAS (casualty) card notes.

- We spent time observing the triage process, with the consent of the patients. We noted that nursing staff also initiated treatment and investigations such as inserting intravenous cannulae, taking bloods and offering analgesia.
- The time-to-treatment for all attendances was 33 minutes, which was significantly better than the national average and target of 60 minutes.
- Although patients could be in the department for up to 24 hours, risk assessments for falls, developing pressure sores and nutrition were not undertaken. We saw limited actions to mitigate individual risks to patients. For example, we saw elderly patients sitting in wheelchairs or armchairs in the observation ward with no evidence of pressure relieving equipment or interventions.

Nursing staffing

- There were insufficient numbers of nurses on duty in A&E to care for patients safely given the severity of patients' symptoms and the geographical layout of the department.
- When we met with senior A&E managers (general manager, clinical lead and nurse service manager) we asked how the nurse staffing complement was decided for the A&E. They told us nurse staffing levels were reviewed annually to take account of changing demand. A specific staffing tool was not used.
- The nurse staffing establishment for the A&E is 69.9 whole time equivalent (WTE) staff. The current vacancy rate was 12.55%. On a typical 24 hours in the department, the following number of nurses were on duty:
  - 10 registered nurses (RN) and two healthcare assistants (HCA) between 7am and 7.30pm
  - Nine RNs and one HCA between 7pm and 7.30am
  - An additional two RNs and one HCA between 11am to 2am.
- The skill mix for each shift included band 7 sister/ charge nurse grades, who were in charge of the shift, with band 6 and band 5 nurses and HCAs. Staff were allocated to specific areas of the department for their shift, but could be moved around if one area became busier than another. However, the six areas of the department (resuscitation, majors A, majors B, triage, observation ward and paediatrics) were geographically separated from each other. The A&E works with the adjacent UCC treating patients with minor ailments or injuries, so patients presenting in A&E are all categorised as majors.
- The department does not meet the RCN BEST recommendation of a nurse patient ratio of 1:1 in resuscitation (high dependency) and 1:2 in majors (moderate dependency). For example, we observed several occasions in resuscitation when the nurse patient ratio was greater than 1:1, which we considered a risk because of the severity of the ill health of the patients. Staff told us this was not uncommon.
- We spoke with several nursing staff who expressed concerns about patient safety when the department was full. Medical staff also expressed concerns about the number of nurses on duty, particularly in resuscitation when a nurse: patient ratio of 1:4 was not uncommon.
- The department was often short of nursing staff in the event of short notice absence, for example, when nurses phoned in sick. We were told it was not always possible to get replacement bank (staff who work overtime in the trust) or agency staff at short notice.
- We observed that nursing staff were well organised and calm during periods of high patient attendance. Handovers between staff were effective. Delegation was clear, and communication skills were good.
- The A&E nursing bank/agency use for the 12 months up to August 2014 averaged 6.2%.

Medical staffing

- The A&E department had 41 WTE medical staff, with a greater number of junior and specialist registrar (StR 1-6) doctors than the England average for other similar size trusts.
- The trust did not meet CEM recommendation that an A&E department should have enough consultants to provide cover 16 hours-a-day, seven days-a-week.
- Five WTE consultants were employed together with the establishment of six WTE consultants. Of A&E medical staff 12% were consultants compared to the

Urgent and emergency services

national figure of 23%. The vacancies had been advertised three times. A proposal for one further WTE was being considered by management. Consultant cover was provided daily from 8am to 6pm on weekdays, and for six hours on Saturday and Sunday with an on-call rota for outside of these hours. A locum consultant was present in A&E between 12 noon and 10pm on weekends.

- The clinical duty rota showed middle and junior grade doctors were on duty 24 hours-a-day in the department.
- Medical agency (locum) use in A&E for 12 months up to August 2014 averaged 2%.

Major incident awareness and training

- The hospital had a major incident plan (MIP), which had last been reviewed in October 2014.Staff were well briefed and prepared for a major incident. They could describe the processes and triggers for escalation. Collaborative arrangements were in place with staff in the UCC to participate in major incidents. We spoke with UCC staff who were knowledgeable about the process and were able to show us polices and action cards. UCC staff told us they had nil hours contracts with the trust in the event of a major incident.
- Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material and hazardous materials and items (HazMat).
- Security staff licensed by the regulator the Security Industry Authority (SIA) were on duty in the hospital. They patrolled the A&E department every 2 hours, recording their visits by an electronic swiping system.
- Of the security staff at the hospital 100% have undertaken the trust's conflict resolution training, and 50% level one safeguarding training.
- Of the staff in the trust's medicine division, which includes A&E, 48% had completed conflict resolution training against the trust target of 80%.
- CCTV was in use in some publicly accessible and high risk areas in A&E such as corridors and medicine storage rooms. Patient areas were not subject to surveillance.

Are urgent and emergency services safe?

Requires improvement

The A&E department requires improvement to ensure that patients are protected from avoidable harm.

Medicines were not always stored securely or checked regularly, which increases the risk of medicine misuse. The trust did not meet the CEM recommendation that an A&E department should have enough consultants to provide cover 16 hours-a-day, seven days-a-week. This compromises senior clinical decision-making, which could negatively impact the patient's care pathway care. Nurse staffing levels did not meet the Royal College of Nursing (RCN) Baseline Emergency Staffing Tool (BEST) recommendations consistently, which compromises patient safety. Tools for monitoring patient's condition were not always used, which increases the risk of undetected deterioration in a patient's conditions.

The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand sanitising gel. The bare below the elbows policy was observed by all staff. Medicine administration records were completed accurately in the patient records we looked at.

Incidents

- There was limited evidence that trends or lessons learned from incident reporting were shared effectively with department staff. We spoke with medical, nursing and allied health professionals who told us they knew how to report incidents and they were given feedback about the outcome if they requested it. Staff said they "occasionally" use the reporting system. Nursing staff told us they were more likely to use the department's hourly report system that captured events (such as overcrowding, patients with challenging behaviours, staff shortages) in real time and was escalated to senior managers. Junior and middle grade doctors said they rarely used the reporting system.
- We asked senior nursing management to demonstrate the reporting system so we could look at a summary of current and outstanding incident reports that they were responsible for reviewing, but they did not have access to the system over the two days of our inspection. There

were no other systems in the department such as hard copies or summaries that captured recent trends or identified the safety priorities raised as a result of incident reporting. A further two senior nurses were unable to access the system to demonstrate it to us because their password had expired, which meant they were locked out of the system.

- A&E reported 13 serious incidents between April 2013 and October 2014. All serious incidents resulted in a root cause analysis (RCA), and action plans were put in place to reduce the likelihood of similar events occurring in the future.
- A serious incident was reported in December 2013 when a patient brought into A&E by ambulance and placed in the waiting room was not seen. The patient was later found collapsed on a chair in the A&E waiting room. The patient was transferred immediately into the resuscitation area and found to have a head injury. RCA concluded the patient was insufficiently observed in the waiting room while waiting to be seen. Actions planned in response included: developing clear pathways for the discharge of homeless patients out-of-hours; training provision around the management of frequent attenders with psycho-social, drug and alcohol dependencies; and ensuring patients are seen in a timely way after being accepted by a clinician.
- A further serious incident was reported in September 2014 when a patient came to A&E with vaginal bleeding following a caesarean section three weeks earlier.
- There were 11 of the 13 incidents that related to breaches of ambulance handover times, none of which resulted in actual patient harm.
- Mortality and morbidity (M&M) meetings were held regularly to review the care of patients who had had complications or an unexpected outcome. Learning was shared and it informed future practice. We looked at minutes of the last three monthly M&M meetings that identified issues about the use of DNA CPR orders in the community. Attendance was limited to A&E medical and nursing staff.

Cleanliness, infection control and hygiene

- A labelling system was used to indicate that an item had been cleaned and was ready for use. The equipment we looked at was clean.
- The treatment areas had adequate hand-washing facilities. We observed staff washing their hands between seeing each patient and using hand sanitising gel. The bare below the elbows policy was observed by all staff.
- We observed that staff complied with the trust policies for infection prevention and control (IPC). This included wearing the correct personal protective equipment (PPE), such as gloves and aprons.
- Side rooms were available for patients who might have a possible cross-infection risk.
- The department was clean and tidy. We saw support staff cleaning the department throughout the day in a methodical and unobtrusive way. Cleaning staff we spoke with knew the areas they were responsible for cleaning, but were unable to provide us with written cleaning schedules.
- Of the staff in the trust's medicine division, which includes A&E, 89% had attended infection control training against a trust target of 95%.
- Between April 2014 and October 2014 A&E reported the following avoidable infections:
  - One incident of MRSA
  - No incidence of Clostridium difficile (C. difficile)
  - Six incidents of MSSA (methicillin-sensitive staphylococcus aureus)
  - 66 incidents of E. coli.
- We spoke with the senior band 7 nurse with a designated responsibility in the department for infection control audits. Audits undertaken show good staff compliance with hand washing and practical infection control techniques. For example, it was used during insertion of peripheral intravenous cannulae and urinary catheters. However, audits demonstrated poor recording of infection control measures in patients' notes.

Environment and equipment

- There was sufficient seating in the waiting room and reception staff had a direct line of sight of most of the area. Vision from the reception area was obstructed by a curved wall in the waiting room. Reception told us there had been a violent incident between patients that they had not seen because of the design of the wall.
- There was a small area to accommodate a trolley for the handover of patients arriving by ambulance.

- There was one triage room near the reception area. Nursing staff told us they sometimes used a cubicle in Majors B if a lot of patients were waiting.
- The resuscitation area had four bays that included a bay designated for the resuscitation of children, which contained a wide range of equipment for patients of all ages. Equipment was clean, regularly checked and ready for use.
- The department had two majors areas. Majors A had eight cubicles and two side rooms. This area was used 24 hours-a-day. Majors B had eight cubicles, one side room used as the eye room and one chair. Staff told us this area was used between 11am and 2am daily and extra nursing staff were rostered to cover the area during these times. Majors B was used outside of these hours when the department required extra capacity.
- There were two further designated rooms for plaster and minor ops.
- There was no separate children's A&E, but provision had been made so children were accommodated in a dedicated area of the department with four individual rooms. There was a paediatric workstation for nurses and medical staff. The separate waiting room for children inside the department had observation windows allowing staff to monitor the area. The children's area was accessible by adult patients and visitors because it was a thoroughfare to exits and other parts of A&E. This compromised the safety of children attending the department and was included in the trust's risk register.
- The six areas of the department were geographically separated from each other by corridors: triage; resuscitation; majors A; majors B; observation ward; and paediatrics.
- A room was available for private and quiet discussions with relatives and an adjoining room was available where relatives could spend time with their loved one in the event of their death.
- Electronic locks maintained a secure environment. There was a facility to lock down A&E in the event of an untoward incident.
- Each bed space in the resuscitation area was designed and configured in exactly the same way. This allowed staff working in that area to be familiar with the bed space, which led to improved working during trauma and resuscitation events.
- A room was designated for interviewing patients presenting with mental ill health. The room had two exits, but we identified ligature points and the storage of portable gas cylinders for use as a potential weapon. This put people at risk of avoidable harm. This was included on the trust's risk register.
- The x-ray department and CT scanning facilities were adjacent to the A&E departments and were easily accessible.

Medicines

- We saw that locks were installed on all store rooms, cupboards and fridges containing medicines and intravenous (IV) fluids. Keys were held by nursing staff.
- On two occasions we found the medicine fridge in the resuscitation area unlocked while no staff were present. Medicine fridges in drug storage rooms were unlocked, but the storeroom door was locked. Fridge temperatures were not regularly recorded, which means staff cannot demonstrate that medicines have been stored at the correct temperature to maintain their effectiveness.
- We saw several practices that increase the risk of medicine error and compromise patient safety. We observed a nurse draw up a syringe from an ampoule and leave it unattended and unlabelled while they went to complete a task in another part of the department before returning to the syringe to complete the labelling. We also observed unlabelled syringes containing clear fluids left on a worktop in resuscitation. There was very limited workspace for preparing medicines in the resuscitation area, which increases the risk of error and contamination. We found nebules of medication for use in nebulisers loose in paediatric cubicles, and bottles of saline and other solutions on shelves on the plaster room and minor ops room, which means they were accessible to the public and children in the department.
- The A&E department was in the trust's top three areas for reporting medicine errors. In the last three-month period the departmentreported 411 medicine error incidents.
- We found that controlled drugs (CD) were regularly checked by staff working in the department. We audited some of the contents of the CD cupboard against the CD register and found it was correct.
- Medicine administration records were completed accurately in the patient records we looked at.
- Of staff in the trust's medicine division, which includes A&E, 84% had completed medicines management training against a trust target of 80%.

Urgent and emergency services

Records

- A paper record was generated by reception staff registering the patient's arrival in the department to record the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- An electronic patient system ran alongside paper records and allowed staff to track patients' movement through the department and to highlight any delays.
- Specific pathway documentation was available for patients presenting with specific conditions, for example a fractured neck of femur. The documents were clear and easy to follow. There was space to record appropriate assessment that included: assessment of risks; investigations; observations; advice and treatment; and a discharge plan.
- We looked at the care records of 10 patients and found they were completed.
- Of staff in the trust's medicine division, which includes A&E, 85% had completed information governance training against a trust target of 90%.

Safeguarding

- Staff we spoke with were aware of their responsibilities to protect vulnerable adults and children. They understood safeguarding procedures and how to report concerns.
- Staff had access to patients' previous attendance history and to regularly updated lists of children identified at risk in their home environment. In addition, children's notes were reviewed by a health visitor to screen for children at risk of harm.
- Of staff in the trust's medicine division, which includes A&E, 89% had completed level one safeguarding adults training against a trust target of 80%. For level two safeguarding adults training 50% of staff in the trust's medicine division, which includes A&E, had completed it against a trust target of 80%.
- Of A&E medical staff 44% had completed training in safeguarding children at level two (ST2) and three (ST3). We were told that trust training records do not distinguish between ST1-3 and ST4 and above. This means the trust cannot demonstrate it meets the recommendation that all senior emergency medicine (EM) doctors (ST4 and above) are trained in safeguarding children at level three as a minimum.
- Of A&E nursing staff 78% had completed training in safeguarding children at level three, and 80% had completed training at level two.

Mandatory training

- Compliance with statutory and mandatory training was generally good. For example, 83% of staff in the trust's medicine division, which includes A&E, had completed fire training, 87% had completed health, safety and risk management training, and 84% had completed patient handling training against a trust target of 95%.

Assessing and responding to patient risk

- Patients arriving by ambulance as a priority (blue light) call were transferred immediately through to the resuscitation area, or to an allocated cubicle space. Such calls were phoned through in advance, so that an appropriate team could be alerted and prepared for their arrival.
- Patients arriving in an ambulance were brought into an area adjacent to the workstation in majors A where the designated nurse in charge took a handover from the ambulance crew. Based on the information received, a decision was made regarding which part of the department the patient should be treated.
- In the 12 months up to August 2014 the trust's A&E scorecard showed the average arrival to assessment time was 16 minutes for patients arriving by ambulance, which was close to the target of 15 minutes.
- NHS England winter pressures daily situation reports (SITREP) data for the trust between November 2013 and March 2014 showed there were 511 occurrences when ambulances waited more than 30 minutes to hand over. This was better than other trusts nationally.
- There was an over reliance on clinical observation and judgement for the monitoring and escalation of deteriorating patients. Early warning scoring tools for adults and children (NEWS/PEWS) were not used in the department, although they were used on wards in the trust. This has been recognised by the recently appointed service lead for nurses, and training was planned and had started to be implemented to embed NEWS/PEWS in A&E. Records we looked at showed observations of patients' vital signs were repeated and recorded for some patients, but there was no specific protocol for frequency or escalation because the EWS tool was not used. This put patients at risk because of the failure to detect deterioration in their condition.

Urgent and emergency services

- For patients walking in to the department, or for people brought into A&E by friends, a streaming system is used. This is provided by the urgent care centre (UCC) and run by Hounslow Richmond Community Health. The UCC was adjacent to the A&E department and shared the large waiting area. We spent some time at the UCC reception and observed an effective streaming process.
- The first point of contact for self-presenting patients was the UCC receptionist, who recorded their details and a brief description of their reason for attending the department. The patient was then immediately passed to a UCC nurse who directed the patient to the UCC or to A&E. A clear protocol was in place to identify patients for care in either UCC or A&E. The streaming nurse gave patients for A&E a card that they took to the A&E reception at the other end of the waiting room. The UCC and A&E shared patients' details electronically.
- Patients were called into the triage room for assessment by a nurse. The A&E used the Manchester triage guidelines to determine the severity of the patient's injury or illness. This was reflected on the department's Symphony system, the electronic A&E patient booking system. But, triage priority was not recorded on the patients' CAS (casualty) card notes.
- We spent time observing the triage process, with the consent of the patients. We noted that nursing staff also initiated treatment and investigations such as inserting intravenous cannulae, taking bloods and offering analgesia.
- The time-to-treatment for all attendances was 33 minutes, which was significantly better than the national average and target of 60 minutes.
- Although patients could be in the department for up to 24 hours, risk assessments for falls, developing pressure sores and nutrition were not undertaken. We saw limited actions to mitigate individual risks to patients. For example, we saw elderly patients sitting in wheelchairs or armchairs in the observation ward with no evidence of pressure relieving equipment or interventions.

Nursing staffing

- There were insufficient numbers of nurses on duty in A&E to care for patients safely given the severity of patients' symptoms and the geographical layout of the department.
- When we met with senior A&E managers (general manager, clinical lead and nurse service manager) we asked how the nurse staffing complement was decided for the A&E. They told us nurse staffing levels were reviewed annually to take account of changing demand. A specific staffing tool was not used.
- The nurse staffing establishment for the A&E is 69.9 whole time equivalent (WTE) staff. The current vacancy rate was 12.55%. On a typical 24 hours in the department, the following number of nurses were on duty:
  - 10 registered nurses (RN) and two healthcare assistants (HCA) between 7am and 7.30pm
  - Nine RNs and one HCA between 7pm and 7.30am
  - An additional two RNs and one HCA between 11am to 2am.
- The skill mix for each shift included band 7 sister/charge nurse grades, who were in charge of the shift, with band 6 and band 5 nurses and HCAs. Staff were allocated to specific areas of the department for their shift, but could be moved around if one area became busier than another. However, the six areas of the department (resuscitation, majors A, majors B, triage, observation ward and paediatrics) were geographically separated from each other. The A&E works with the adjacent UCC treating patients with minor ailments or injuries, so patients presenting in A&E are all categorised as majors.
- The department does not meet the RCN BEST recommendation of a nurse patient ratio of 1:1 in resuscitation (high dependency) and 1:2 in majors (moderate dependency). For example, we observed several occasions in resuscitation when the nurse patient ratio was greater than 1:1, which we considered a risk because of the severity of the ill health of the patients. Staff told us this was not uncommon.
- We spoke with several nursing staff who expressed concerns about patient safety when the department was full. Medical staff also expressed concerns about the number of nurses on duty, particularly in resuscitation when a nurse: patient ratio of 1:4 was not uncommon.
- The department was often short of nursing staff in the event of short notice absence, for example, when nurses phoned in sick. We were told it was not always possible to get replacement bank (staff who work overtime in the trust) or agency staff at short notice.
- We observed that nursing staff were well organised and calm during periods of high patient attendance. Handovers between staff were effective. Delegation was clear, and communication skills were good.

Urgent and emergency services

- The A&E nursing bank/agency use for the 12 months up to August 2014 averaged 6.2%.

Medical staffing

- The A&E department had 41 WTE medical staff, with a greater number of junior and specialist registrar (StR 1-6) doctors than the England average for other similar size trusts.
- The trust did not meet CEM recommendation that an A&E department should have enough consultants to provide cover 16 hours-a-day, seven days-a-week.
- Five WTE consultants were employed together with the establishment of six WTE consultants. Of A&E medical staff 12% were consultants compared to the national figure of 23%. The vacancies had been advertised three times. A proposal for one further WTE was being considered by management. Consultant cover was provided daily from 8am to 6pm on weekdays, and for six hours on Saturday and Sunday with an on-call rota for outside of these hours. A locum consultant was present in A&E between 12 noon and 10pm on weekends.
- The clinical duty rota showed middle and junior grade doctors were on duty 24 hours-a-day in the department.
- Medical agency (locum) use in A&E for 12 months up to August 2014 averaged 2%.

Major incident awareness and training

- The hospital had a major incident plan (MIP), which had last been reviewed in October 2014.Staff were well briefed and prepared for a major incident. They could describe the processes and triggers for escalation. Collaborative arrangements were in place with staff in the UCC to participate in major incidents. We spoke with UCC staff who were knowledgeable about the process and were able to show us polices and action cards. UCC staff told us they had nil hours contracts with the trust in the event of a major incident.
- Decontamination equipment was available to deal with casualties contaminated with chemical, biological or radiological material and hazardous materials and items (HazMat).
- Security staff licensed by the regulator the Security Industry Authority (SIA) were on duty in the hospital. They patrolled the A&E department every 2 hours, recording their visits by an electronic swiping system.
- Of the security staff at the hospital 100% have undertaken the trust's conflict resolution training, and 50% level one safeguarding training.
- Of the staff in the trust's medicine division, which includes A&E, 48% had completed conflict resolution training against the trust target of 80%.
- CCTV was in use in some publicly accessible and high risk areas in A&E such as corridors and medicine storage rooms. Patient areas were not subject to surveillance.

Are urgent and emergency services effective?

(for example, treatment is effective)

Requires improvement

The department used a combination of the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. A range of clinical care pathways had been developed in accordance with this guidance.

We observed that an assessment of pain was undertaken on patients when they arrived in the department. All of the patients we spoke with told us that they were offered and/or provided with appropriate pain relief.

The mortality rates for the trust were as expected for a hospital of its size.

The trust performed poorly in the 2011 CEM consultant sign-off audit, and was worse than other trusts in England. It had taken steps to improve results though more work was needed.

We saw excellent team working between medical and nursing staff throughout our visit.

All areas of A&E were open seven days-a-week. Support services were also available seven days-a-week, which included x-ray, scanning and pathology.

Evidence-based care and treatment

- The department used a combination of the National Institute for Health and Care Excellence (NICE) and College of Emergency Medicine (CEM) guidelines to determine the treatment they provided. A range of clinical care pathways had been developed in accordance with this guidance.

- Specialities had access to care bundle/pathway documentation for some conditions such as fractured neck of femur, community-acquired pneumonia and sepsis.
- Clinical guidelines were accessible electronically, and we saw an example of a printed copy in the case notes of a patient who was being treated for a paracetamol overdose.
- Posters of current clinical guidelines and pathways were displayed in the resuscitation bays.
- The department participated in national audits such as pain relief, and also local audits that included hand hygiene.
- There was a procedure for admitting patients to the observation ward, but no clear guidelines on the appropriateness of patients.

Pain relief

- We observed that an assessment of pain was undertaken on patients when they arrived in the department. All of the patients we spoke with told us that they were offered and/or provided with appropriate pain relief. Patients' records confirmed this.
- Pain scoring tools were not used in the department, which meant the efficacy of analgesia could not be measured.
- We did not see any patient displaying verbal or non-verbal signs of pain during our inspection that was not being addressed by the staff.

Nutrition and hydration

- Although there were no food and drink comfort rounds in the department, staff offered food and drinks to people as they thought necessary, depending on the length of the patient's stay. Sandwiches were delivered to the A&E kitchen at lunchtime and staff could make toast for patients in the kitchen. Meals could be ordered for patients in the observation ward. We saw staff providing drinks, breakfast and sandwiches to patients during our inspection.
- The department did not use nutritional risk assessment tools, although patients could spend up to 24 hours in A&E.
- We observed that intravenous fluids were prescribed and recorded appropriately.

Patient outcomes

- The mortality rates for the trust were as expected for a hospital of its size.
- The trust performed poorly in the 2011 CEM consultant sign-off audit, and was worse than other trusts in England. The clinical lead told us that in response to the CEM audit results an additional senior sign off column had been added to the Symphony system for patient monitoring. However, we were told that in practice it was not always done by consultants, but by middle grade doctors. We discussed this with several medical staff who told us that junior doctors would discuss all discharges of any complex patients.
- The trust did not meet any of the CEM standards in the fractured neck of femur audit 2012, and performed worse than other trusts in England. The trust told us that since the audit there had been an improvement in time to x-ray and time to analgesia for fractured neck of femur patients.
- The trust did not meet any of the 13 CEM standards for vital signs in majors in the 2012 audit, and performed worse than the England average for 12 of the 13 standards. The trust told us that monitoring of vital signs for majors was subsequently established with the use of the early warning score across the department.
- The trust met three of the 14 CEM standards for the treatment of renal colic in the 2012 audit, and performed better than the England average for six of the 14 standards.
- The trust met one of the 13 CEM standards for the treatment of severe sepsis and septic shock, and was better than the England average for six of the 14 standards. The trust told us that there had been an improvement in the reduction of sepsis and there was ongoing work around other audits to build on this.
- A&E did not meet the national standard for the rate of unplanned re-attendances from January 2013 to May 2014, and performed worse than the England average. The trust told us that a team had been set up to reduce the number of repeat visits by frequent attenders and that as a result of this the average number of visits per year had reduced from 32.3 to 6.8.

Competent staff

- There were 14 paediatric-trained nurses in A&E, so that the area designated for children was always staffed with nurses who had appropriate qualifications to care for acutely ill children.
- Children that required specialist paediatric services were treated by paediatric doctors from the children's ward.

- Of staff in the trust's medicine division, which includes A&E, 71% had completed adult basic life support (BLS training) against the trust target of 80%.
- Junior doctors told us they were well supported and had weekly training sessions.
- Nursing staff had departmental clinical learning sessions, often held at the morning handover.
- Staff were appraised regularly, and we found that 88% of nursing staff and 80% of medical staff in the trust's medicine division, which includes A&E, had received a recent appraisal.

Multidisciplinary working

- The streaming system for patients who self-present at A&E was provided by Hounslow CCG at the adjacent Urgent Care Centre (UCC). We spoke with the service manager and lead GP at the UCC who told us there were excellent working relationships and effective communication between the departments. Regular monthly meetings were held between the two departments, and telephone or face-to-face contact was daily.
- We saw excellent team working between medical and nursing staff throughout our visit.
- Medical and nursing staff worked across A&E with other specialists and therapy staff to provide multidisciplinary care.
- An A&E therapist team made up of a physiotherapist and occupational therapist provided a seven-day service to promote discharge with appropriate support. The team assessed patients who required packages of care or specialist equipment. For example, we saw a patient provided with a raised toilet seat to take home with them. The team had clear guidelines and protocols and were able to demonstrate through data collection the positive impact of their intervention in facilitating discharge.
- The A&E was well supported by the adjacent radiology department for x-ray, and most requested CT scans were performed in one hour.
- Staff had access to the mental health crisis team to assess and treat patients with acute mental ill health conditions, with a 30 minute response to referral available 24 hours-a-day.
- The British Red Cross provided a service to facilitate discharge from A&E when a patient was medically fit, but had social rather than medical reasons that prevented a safe discharge.

Seven-day services

- All areas of A&E were open seven days-a-week. Support services were also available seven days-a-week, which included x-ray, scanning and pathology.
- Physiotherapists and occupational therapists offered a seven-day service to patients.
- An A&E consultant on-call rota was available to support out-of-hours and seven-day working. Middle grade doctor cover was available at all times.

Access to information

- The department had a computer system that showed how long patients had been waiting, their location in the department and what treatment they had received.
- A paper record, or cas card, was generated by reception staff when they registered the patient's arrival. It recorded the patient's personal details, initial assessment and treatment. All healthcare professionals recorded care and treatment using the same document.
- Staff could access records including test results on the trust's computerised system.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We observed patients being asked for verbal consent to care and treatment. Patients told us that interventions were explained in a way that they could understand before they were carried out.
- Of staff in the trust's medicine division, which includes A&E, 70% had completed consent training against the trust target of 80%.
- Staff we spoke with were clear about their responsibilities about how to gain consent from patients, including people who lacked capacity to consent to their care and treatment.
- When patients lacked the capacity to make informed decisions we observed staff following the principles of the Mental Capacity Act 2005. This applied to patients who had arrived at A&E who were unconscious or under the influence of a substance. However, patients' capacity and any best interest decisions were not recorded in the patient records.
- There were no secure areas where high-risk mental health patients could be accommodated. The interview room was used solely to carry out psychiatric assessments, and patients were not left there unsupervised. Patients, who were at risk of harm, or at risk of absconding, were cared for in the majors area

where they were supervised closely. Staff told us that additional nursing staff or security staff could be called to assist with patient supervision and to prevent patients absconding.
- We saw appropriate mental health referral practices.
- The trust used privately contracted security staff, and we spoke to them about their role in A&E. They described the supervision of patients presenting with challenging behaviours, such as those intoxicated by substance misuse and patients with mental ill health that included dementia. Security staff said they also assisted with patients who absconded, and they explained that they had a strictly hands off approach. This was corroborated by nursing staff.
- SIA-licenced security staff received training in: control and restraint for manned guarding; door supervision; or security guard. They had limited training for the patient groups they worked with in A&E. For example, they had not received any awareness training about the conditions that patients might present such as mental ill health or dementia.

Are urgent and emergency services caring?

Good

A&E provided a caring and compassionate service.

We observed staff treating patients with respect. Patients and their relatives and carers told us that they felt well-informed and involved in the decisions and plans of care. We saw that staff respected patients' choices and preferences and were supportive of their cultures, faith and background.

Compassionate care

- Throughout our inspection of A&E we saw that staff treated patients with compassion, dignity and respect. People's privacy was respected and curtains were drawn when personal care was given. Staff lowered their voices to prevent personal information being overheard by other patients.
- During our inspection demand for beds in A&E became so great it was necessary to declare an internal incident or code black. It was commendable that despite the extra pressure put on all staff during this period, patients and relatives told us staff continued to be caring and compassionate.
- The Friends and Family Test (FFT) results for October 2014 were displayed on a board in the reception area. The results showed that 92% were extremely likely or likely to recommend the service.
- The patients and relatives we spoke with during our inspection told us staff were caring and considerate. Their comments included: "I've been here many times, and they always look after me very well"; and "they are all very kind."

Patient understanding and involvement

- The A&E department scored 8.6 out of 10 in the 2013 Care Quality Commission (CQC) inpatient survey, which was about the same as other trusts. The survey asked patients about how much information about their care and treatment was given to them.
- When patients were asked about whether they were given enough privacy during examinations or treatment in A&E, the department scored 8.3 out of 10 in the 2013 CQC inpatient survey. This was about the same as other trusts.
- A "You Said, We Did! "display in the waiting area summarised three comments about A&E. Two were of thanks, and the third comment said: "Too many passing round of notes." However, the trust's response to this comment was not displayed.
- Patients and relatives told us that their care and treatment options were explained to them in way they could understand. Their comments included: "Staff are very efficient and they explain what they're doing"; and "I know the plan for my treatment – they told me about it, so I didn't have to ask."
- In the 2014 A&E Survey which covered questions about patient experience for arrival at A&E, waiting time, attitude of doctors and nurses, care and treatment, patient tests, hospital environment, leaving A&E and experience overall the hospital scored about the same as other trusts that took part in the survey.

Emotional support

- We spoke with staff about caring for relatives who had just lost a loved one in A&E. We were informed family members were taken to the relatives' room. Where possible, their loved one was placed in the adjoining viewing room, and relatives were given the opportunity

to spend time with them if they wished to. We were informed relatives could stay as long as they wished to in the department after a patient's death, drinks were provided and patients were not moved until the relatives were ready.
- We observed staff responding compassionately following a death in the department. Relatives were treated sensitively and were not rushed.
- Staff told us that there were good links to sources of specialist support, such as counselling and chaplaincy services.
- A&E staff initiated and help set up a support group for bereaved parents.

Are urgent and emergency services responsive to people's needs?
(for example, to feedback?)

Requires improvement

Improvements are required in the way services are organised and delivered in the A&E department to meet people's individual needs.

The service did not fully take into account the needs of the local multicultural communities. Services were not delivered in a way that focuses on people's holistic needs such as those living with dementia. The facilities and premises did not always promote people's privacy, dignity and confidentiality. Patient flow was poor, and waiting times were above the national average due to capacity constraints. This meant patients were not transferred to areas treating their speciality, but were accommodated in A&E for longer than necessary.

Service planning and delivery to meet the needs of local people

- The trust serves people living in the London boroughs of Hounslow and Richmond on Thames. The 2011 census shows that, although Richmond has a population of 187,000, it is one of the least ethnically diverse boroughs in the capital. However, half of Hounslow's 213, 000 population came from an ethnic minority.
- Patients who attended the department spoke many languages. Most patients went to the hospital with a family member who acted as an interpreter. This is recognised as poor practice. Telephone translation services were available for patients who did not have English as their first language, and some staff spoke more than one language.
- Patient information and advice leaflets were available in English, but were not available in any other language or format.

Access and flow

- The flow of patients from the A&E to other parts of the hospital required improvement.
- The A&E department was consistently significantly better than the national average time-to-treatment in less than 60 minutes. Between April and August 2014 the trust's A&E scorecard shows an average time-to-treatment of 35 minutes.
- The national target is that 95% of A&E patients wait less than four hours to be admitted, transferred or discharged. The A&E scorecard showed that the trust is failing to meet this target. Between April and August 2014 the target was achieved for 93% patients.
- There were a number of reasons why patients breached the four-hour target. These included: no bed available on a ward; a delay in A&E review; a delayed specialty review such as to a surgical team; a delay in transport; waiting for a community care package to be put into place; or a clinical issue that required the patient to remain in the department for longer.
- The trust had an escalation plan that set out clear pathways and processes that needed to be followed if the demand for beds in A&E increased. This covered normal patient numbers (code green), and escalated to the declaration of a code black for critical status when the department is unable to provide a safe level of care because of high levels of patients attending A&E. During our announced inspection the department was escalated to code black. The department experienced 70 breaches of the four-hour target overnight.
- We attended a trust-wide bed capacity meeting. Several wards were full, and some wards had an escalation plan in place. Also, there were no other paediatric beds in the local area. The A&E nurse service manager had an excellent overview of the situation and led the meeting very effectively to ensure patient flow was maintained as much as possible. All A&E staff demonstrated resilience and professionalism during this challenging period.

Urgent and emergency services

- Staff in the department responded appropriately to the individual needs of patients who were accommodated in the department overnight. Patients were provided with beds, rather than lying on trolleys, and were given food and drinks.
- The total average time a patient stayed in A&E was consistently significantly higher than the national average. Between April and August 2014 the trust's scorecard shows patients spent an average 290 minutes in the department. The national average for the same period was less than 140 minutes.
- The UCC refers 15 to 20 patients to specialities in the trust every day, and three or four of these patients require admission. The patients do not go directly to wards or assessment units, but are admitted through the A&E department.
- The Department of Health regards the number of patients who leave A&E before being seen as a potential indicator of patient dissatisfaction with the length of waiting time. The trust performed better than the national average for the number of patients who left without being seen. Between April and August 2014 the figure for the trust was 2.7% of A&E patients.

Meeting people's individual needs

- There was a large waiting room with sufficient seating shared by A&E and UCC.
- Several people told us they did not understand the streaming process and were unclear about the difference between the UCC and A&E. This caused frustration for people waiting to be seen.
- Information about waiting times was displayed on an electronic screen beside the A&E reception. The waiting times displayed was two hours for minors and four hours for majors. However, this was misleading because A&E only saw major's patients, while minors were streamed to UCC and people waiting were unfamiliar with this jargon of majors and minors. The waiting times displayed during our inspection did not change. Reception staff told us they did not know how to alter the display. Staff could not be confident that the waiting times displayed were accurate.
- Two receptionists and the streaming nurse sat behind three windows at the reception desk. There were no dividers between the three windows, so confidential conversations about a patient's conditions could be overheard. We observed several patients being asked to put their ear near the aperture in the window for their temperature to be taken. We observed an incident when a patient was asked to raise their trouser leg so the nurse could look over the top of the desk at a wound.
- Patients streamed to A&E were sent to the department's reception at the other end of the waiting room. They were booked in by a receptionist and then waited to be seen by the triage nurse, who talked to them privately in a designated room.
- There was a separate waiting area for children with age-appropriate toys.
- The needs of people living with dementia were not being met. The trust's own data indicated that 33% of patients have a delirium or dementia. Staff had not received training. Programmes to support people living with dementia were not implemented. For example, the Alzheimer's Society provides a wide range of training and publications to support healthcare staff such as the Dementia Friends initiative.
- We looked at the relatives' room where people waited while their seriously ill relatives were cared for, or where people were informed that a relative had passed away. We found that it was in good condition with clean furniture and tea and coffee-making facilities. It was adjacent to a viewing area where people could see their deceased relative.
- The observation ward was divided into two areas to provide separate accommodation for male and female patients. Each area had two beds and four chairs, and patients were accommodated for a maximum stay of 24-hours. Separate toilet and showering facilities were available in each area. However, there was no wall or partition between the two areas, and male patients had to walk through the female area to access their accommodation. This compromised patients' dignity and privacy.
- There were no privacy curtains in the resuscitation areas. Mobile screens were used, but these were insufficient to maintain privacy.

Learning from complaints and concerns

- Informal complaints could be received by any member of the team. These were dealt with by the most appropriate person. Staff were aware that if they could not resolve an issue they should advise the patient/relative how to use the formal complaints policy.
- Of staff in the medicine division, which includes A&E, 48% had completed conflict resolution training.

Urgent and emergency services

- Complaints were handled in line with trust policy. If a patient or relative wanted to make an informal complaint they were directed to the nurse in charge of the department. If it was not possible to resolve the concern locally, patients were referred to the Patient Advice and Liaison Service (PALS), which would log their complaint formally and attempt to resolve the issue within a set period. PALS information was available in the main A&E.
- Staff we spoke with were familiar with the complaints process and told us they directed dissatisfied patients to the PALS service when appropriate. Information about how to complain was displayed in the department. Information leaflets were available to all patients. They contained helpful information about how to access PALS and how to make a complaint.
- Formal complaints were investigated by the matron and/or a consultant, and responses were sent to the complainant. Information provided by the trust showed the department usually met the target for closing complaints in an agreed response date.
- The department recorded 28 complaints in the last 12 months: eight related to staff attitude; six concerned care and treatment; and four involved missed diagnoses. There were no particular trends seen among the remaining 10 complaints, and 21 were upheld or partially upheld. Six complaints remained under investigation.

Are urgent and emergency services well-led?

Requires improvement

The systems to identify and manage risk in A&E need to be strengthened to support the delivery of safe and effective care. Staff satisfaction was mixed. Some staff were very positive but other staff did not feel fully engaged. Some staff described a blame and bullying culture. The sustainable delivery of quality care in the A&E is put at risk by the financial challenges faced by the trust.

Quality and patient experience were seen as everyone's responsibility. There was positive feedback from trainee doctors who had been on placement in the department.

Vision and strategy for this service

- The divisions and departments in the trust did not have an individual vision or values. Trust-wide vision and values were not embedded among staff. We had varied responses from staff when we asked them to describe the trust's vision and values. Some staff said they did not know what the vision and values were while others described aspirations. For example, aspirations included: be friendly; be welcoming; and provide safe care. Only very senior managers described the trust's vision of a first class hospital for our community.
- The trust was designated as financially-challenged, and it is pursuing a merger with Chelsea and Westminster Hospital NHS Foundation Trust. Most staff were aware of the potential merger, but knew of no specific time frame. Several staff commented: "It's been talked about for a long time." The long-term strategy is to achieve foundation trust status through the partnership.
- The trust expects that changes in the local health economy will result in annual increased A&E attendances by 12,000. The trust recognises that the physical space in the A&E is a challenge. The trust is involved in the Shaping a Healthier Future (SaHF) North West London reconfiguration strategy. A staged investment plan was approved by the board in October 2014, and priorities for 2014/15 have been agreed with commissioners. An expansion of the A&E was at an advanced planning stage. Most staff working in the A&E were unfamiliar with SaHF, so they were not engaged with it.
- Trust strategies mostly address longer term issues. Although the lack of physical space in A&E was recognised as a current and ongoing concern, there was no evidence of immediate action taken to tackle it or to plan for increase in activity. The trust was relying on the longer term SaHF and merger plans.

Governance, risk management and quality measurement

- The trust maintained a system of scorecards for monitoring targets. For example, this included national performance targets, patient experience and clinical quality. These were accessible for staff reference.
- We asked the trust for copies of recent departmental governance meetings. We were told that meetings have

only recently been initiated. The minutes of the first meeting that took place in October 2014 were unavailable because the interim operations manager for emergency services was on leave.

- The department had four identified risks on the trust-wide register. These related to: A&E performance against national targets; safety of the room for interviewing patients with mental ill health; safety in the waiting room; and the accessibility of the children's area to other patients/public. Other risks in the department were omitted from the risk register such as violence and aggression towards staff and staffing levels (medical and nursing). There was consistency between what frontline staff and senior staff said were the key challenges faced by the service. For example, this included capacity and flow. However, there was limited evidence of any action plans for improvement.

Leadership of service

- The A&E was part of the trust's medicine division. The structure of the A&E department included: a clinical lead (an emergency care consultant); head of nursing for emergency and site services; and an operations service manager .The operations service manager was on unplanned leave during our inspection.
- There had been a very recent change in the department's nursing lead, and the role had been extended to include site services to oversee capacity and flow. Staff told us they felt the appointment had a positive impact because of strong leadership qualities, visibility on the floor and clinical skills of the head nurse. All staff were clear about their lines of supervision.

Culture within the service

- Staff in the department spoke positively about the care they provided for patients. Quality and patient experience were seen as everyone's responsibility.
- There was positive feedback from trainee doctors who had been on placement in the department. They said they had been made to feel part of the team, and staff ensured that they were fully involved in all aspects of patient care and treatment.
- There were several ongoing performance management and grievance issues among nursing staff in the department that caused an atmosphere of some wariness and apprehension. Several staff told us they believed they had been treated unfairly by the trust.
- A number of staff told us they felt senior trust managers were oppressive and overbearing. They felt there was sometimes too strong a focus on performance targets, and nursing staff were often blamed for failure to meet targets. Several staff told us that they had experienced bullying or had witnessed it.

Public and staff engagement

- All patients were encouraged to take part in the FFT. Results were displayed in the waiting area.
- Most A&E staff were not aware of the corporate strategic objectives outlined in the trust's business plan, so could not describe how their role supported the plan.

Innovation, improvement and sustainability

- During our inspection there was a Managed Care Appropriate Protocol (MCAP) audit taking place in the department. One band 7 and one band 6 nurse were seconded for 30 and 25 hours-a-week respectively from August 2014 until March 2015. The purpose was to provide additional insight into clinical decision-making to ensure patients were given the right care in the right place. The project was retrospective at the time of our inspection, but was proposing to go live before the end of the year.
- An initiative led by A&E nursing staff to offer specific support for the individual psycho-social issues of people identified as frequent attenders to the department was having a positive impact.

Medical care

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

Information about the service

The West Middlesex University Hospital NHS Trust provides a number of medical services that includes: cardiology; gastroenterology; respiratory medicine; endocrinology; haematology; and acute stroke services. The trust also provides services to elderly patients and people living with dementia.

We inspected: ambulatory emergency centre (AEC); acute assessment unit (AAU); two acute medical units (AMU1 and 2); coronary care unit (CCU); Osterley 1 ward (acute medicine); Osterley 2 ward (acute medicine); Kew ward (acute stroke); Marble Hill 1 ward (general medicine); Marble Hill 2 ward (escalation beds); Lampton ward (heart failure); and Crane ward (care of elderly).

We spoke with 37 patients,15 family members and 58 staff members that included: clinical leads; service managers; matrons; ward staff; therapists; junior doctors; consultants; and other non-clinical staff. We observed interactions between patients and staff, considered the environment and looked at medical records and attended handovers. We reviewed other documentation from stakeholders and performance information from the trust.

Summary of findings

The trust is good at keeping its medical patients safe, and runs an innovative heads-up: what happened yesterday process. This provides a structured approach during staff handovers that ensures safety concerns are identified and dealt with at an early stage.

Care was provided in line with national best practice guidelines. Clinical audit was undertaken and there was good participation in national and local audit, which demonstrated good outcomes for patients. We observed good clinical practice by clinicians during our inspection.

Most patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them. One person told us “the staff are very good indeed, they can’t do enough for you, to be quite honest, even the doctors I see are good”.

People who were living with dementia were not identified quickly enough, or at all during their stay in the hospital. Those patients who were identified were not receiving the additional support that they needed for their care. Staff were not sufficiently trained to support patients who were living with dementia or people living with a learning disability.

The medical division was well led, and managers had a clear understanding of the key risks and issues in their area. Ward staff felt well supported by their ward sisters, and matrons and told us they could raise concerns with

them. Ward managers and ward sisters were passionate about improving services for patients and providing a high quality service. The most consistent comment we received was that the trust was a friendly place and people enjoyed working there.

Are medical care services safe?

Good

The trust runs an innovative heads-up: what happened yesterday process. This provides a structured approach during staff handovers that ensures safety concerns are identified and dealt with at an early stage. Staff use a form to record what the concern was, what has been done and what still needed to be done to reduce the risk and ensure the learning is implemented.

Between May 2013 and May 2014, the medical division had a lower number of falls, pressure ulcers and new urinary tract infections (UTIs) than the England average.

Staff generally followed the trust infection control policy. We observed that staff regularly washed their hands in between seeing patients, used personal protective equipment (PPE) such as gloves and aprons and adhered to the trust's bare below the elbows policy. We noted that staff visitors to wards such as porters and maintenance staff did not always use the hand sanitisers as they entered the wards.

There were enough medical and nursing staff to keep patients safe at all times. Staff handovers were well managed with key issues identified, recorded and action to ensure patients who were unwell were monitored and supported.

Incidents

- There had been one Never Event (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) in the medical division between April 2013 and March 2014. This is in line with other similar trusts in England.
- Between April 2013 and March 2014 the medical division reported 50 serious incidents through the National Reporting and Learning System (NRLS). Grade three and four pressure ulcers accounted for the highest number of incidents.
- Staff we spoke with stated they were encouraged to report incidents. Staff knew how to report an incident and said they did this frequently. Nursing staff told us they received feedback on the incidents they had reported.

Medical care

- The trust runs an innovative heads-up: what happened yesterday process. This provides a structured approach during staff handovers that ensures safety concerns are identified and dealt with at an early stage. Staff use a form to record what the concern was, what has been done and what still needed to be done to reduce the risk and ensure learning is implemented. Staff we spoke to were all aware of the scheme and were very positive about it. During the three staff handovers we attended, we observed the scheme was being used and staff were confidently highlighting issues.
- Incidents reviewed during our inspection demonstrated that investigations and root cause analysis took place, and action plans were developed to reduce the risk of a similar incident recurring. For example, a nursing sister told us that she had recently reviewed the three falls that had occurred on her ward in the last month. Two of them had been identified as avoidable and procedures had been changed to ensure that all patients who had a high risk of falling were provided with anti-slip socks.
- Staff on the CCU were able to describe the learning they had obtained from a root cause analysis investigation into a patient who had potentially been given the wrong dose of an antibiotic. Although the investigation revealed the right dose had been given to the patient, general learning about the use of the antibiotic had been obtained and disseminated.

Safety thermometer

- The division used the NHS Safety Thermometer, an improvement tool to measure, monitor and analyse patient harms and 'harm-free' care. A monthly snapshot audit of the prevalence of avoidable harms was carried out to monitor performance in: new pressure ulcers; catheter-related urinary tract infections; venous thromboembolism (VTE); and falls.
- Between May 2013 and May 2014 the hospital had a lower number of falls, pressure ulcers and new urinary tract infections (UTIs) than the England average.
- Staff we spoke to had a good knowledge of how to reduce the risk of patients developing pressure ulcers. Staff knew which patients were at high risk, and could describe the actions they had taken to reduce the risk to those patients such as using special mattresses and ensuring patients did not spend too long in one position.
- We found that Safety Thermometer information was displayed in a very inconsistent way on ward notice boards. Some wards had no information, or information that was difficult to interpret, whereas some wards had good information for patients, visitors and staff.

Cleanliness, infection control and hygiene

- All of the wards we visited were visibly clean, and cleaning schedules were clearly displayed on the wards.
- Hand hygiene gel was available at the entrance to every ward and along corridors. There was clear signage at these locations directing people to sanitise their hands.
- Staff generally followed the trust infection control policy. We observed that staff regularly washed their hands in between seeing patients, used personal protective equipment (PPE) such as gloves and aprons and adhered to the trust's bare below the elbows policy. We noted that staff visitors to wards such as porters and maintenance staff did not always use the hand sanitisers as they entered the wards.
- There were isolation procedures, and we observed these being used appropriately. For example, staff were able to explain why some patients had been placed in an isolation room while others had not.
- Hand hygiene audits were carried out monthly with the results placed on the ward notice board. We found compliance rates of between 87% and 100%.
- The trust's MRSA infection rate was lower in comparison to trusts of similar size and complexity, as it was for Clostridium difficile infection rate. All patients were screened for MRSA while on the AMU.

Environment and equipment

- We observed that each ward area had sufficient moving and handling equipment to enable patients to be cared for safely.
- Equipment was maintained and checked regularly to ensure it was safe to use .The equipment was clearly labelled stating the date when the next service was due.
- We examined the resuscitation equipment on each ward. There had been regular checks of resuscitation equipment, which had been documented.

Medicines

- Medication were always stored securely. Rooms where medicines were stored were always locked.
- Emergency medication and resuscitation trolleys were checked daily on all of the wards we visited.

- Fridge temperatures were monitored and recorded at the required intervals.
- The pharmacist visited all wards daily. Staff told us the pharmacy services were readily available and they could contact the pharmacist whenever required.
- Pharmacists undertook regular audits of controlled drug management on all clinical areas that stocked controlled drugs. All wards were expected to achieve 100% compliance with each of the individual standards audited.
- However on Marble Hill 2 ward we found that patients or family regularly had to return to the ward the next day to collect their discharge prescription.

Records

- Records were kept in both paper and electronic format, and all healthcare professionals documented in the same record. Nursing observations were kept by the patient's bed. Patients' records were appropriately completed and were legible with entry dates, times and designation of the person documenting indicated.
- We examined a number of notes on each ward we visited. The pressure ulcer, nutrition, moving and handling and falls risk assessments that we looked at were fully completed and reviewed on a weekly basis.
- Patient information and records were stored securely on all wards.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients were consented appropriately. We saw that where patients did not have the capacity to give consent to their treatment the Mental Capacity Act 2005 was appropriately implemented.
- Staff were able to describe the correct process for obtaining consent for a patient who had a limited capacity to make their own decisions. They were able to give examples where they had involved families and independent advocacy to support the patient.
- We found examples of patients who appeared to have limited capacity, but that this had not been recorded in their notes and it was not clear how they were being supported with their decision-making.

Safeguarding

- There were safeguarding policy and procedures that staff were aware of.
- Information provided by the trust on its medical scorecard indicated how many staff had received child safeguarding training, but there was no information on adult safeguarding training performance.
- Staff were able to describe situations in which they would raise a safeguarding concern and how they would escalate any concerns. Staff we spoke to were able to give examples of when they had used the trust's safeguarding policy to raise concerns.

Mandatory training

- Mandatory training covered a range of topics that included: fire safety; health and safety; basic life support; child safeguarding; manual handling; hand hygiene; and information governance. Most staff told us they were up-to-date with their mandatory training.
- Data provided by the trust in July 2014 showed 85.5% of staff had completed mandatory fire training, which was above the trust target of 85%. However, for the same period only 90% of staff had completed infection control training compared to the trust target of 95%.
- There was an induction programme for all new staff, which staff who had attended this programme felt met their needs. All new staff we spoke to said they had completed the induction training.

Management of deteriorating patients

- Risk assessments were undertaken in areas such as VTE, falls, malnutrition and pressure ulcers. These were documented in the patient's records and included actions to mitigate the identified risks.
- Staff used the National Early Warning Score (NEWS) process, and medical and nursing staff were aware of the appropriate action to take if patients scored higher than expected. The completed NEWS charts we looked at showed that staff had escalated patients appropriately, and repeat observations were taken in the necessary time frames.
- Situation, Background, Assessment, Response (SBAR) labels were used in patient records to identify deteriorating patients easily.
- Staff felt well supported by doctors when a patient's deterioration was severe and resulted in an emergency.
- We noted a patient on Kew Ward was not wearing a wrist band so that staff could ensure they received safe treatment aimed at that individual. We pointed this out to the ward manager, who immediately provided the patient with a wrist band.

Medical care

Nursing staffing

- Nursing staffing levels had been reviewed and assessed using the National Safer Nursing Care Tool. The division had carried out an acuity and dependency audit in July 2014, which had set minimum and desirable nursing levels for each ward.
- Most nursing staff on the medical wards were aware that the trust had used an acuity tool. Staff felt that senior managers would listen to their concerns about staffing levels. We found that there were more nurses in areas of high need such as the stroke ward. One patient told us: "They are always coming and checking on you."
- Data provided by the trust indicated that the nursing staff vacancy rate across the medical division was 10.4%. Managers were aware of their vacancy rate and have undertaken a number of initiatives that included the recruitment of nurses from abroad.
- The CCU always has at least two coronary trained nurses on duty to ensure that specific incidents were responded to by experienced specialist coronary nurses.
- The trust had a very low sickness absence rate compared to the England average.
- Nursing staff told us that most of the time they had enough staff, but then when things became busy they became stretched. One physiotherapist told us: "They do their best, but they often don't have enough staff to help patients with sitting out by their beds."

Medical staffing

- There were enough doctors to fill the medical roster and ensure that patients were kept safe at all times.
- In responding to the General Medical Council (GMC) doctor's survey in 2013, junior doctors indicated that workloads were too high in the core medicine and care of the elderly specialisms. As a result, the trust recruited two additional junior doctors. In addition, they also introduced the ambulatory care service to reduce the number of admissions.
- Staff told us that all patients admitted were seen by a consultant within 12 hours.
- Junior doctors felt there were adequate numbers of junior doctors on the wards out of hours and that consultants were contactable by phone if they needed any support by both the middle grade doctors and consultants.
- We observed the medical handover in the morning with the hospital at night team. The process was led by the day consultant. The hospital at night team is led by a registrar and two other junior doctors. All the staff we spoke to felt that this provided enough medical capacity to keep patients safe at night.
- Senior staff told us that the trust did not get a fair share of medical trainees compared to other similar size hospitals in the area.

Major incident awareness and training

- Staff we spoke to were aware of the procedure for managing major incidents such as winter pressure and fire safety incidents. During the three days of our inspection there was a large influx of new patients, mostly with medical conditions. We observed that the hospital responded to this sudden increase in demand well. Escalation beds were opened on Marble Hill 2 ward. When we visited the ward we found the atmosphere was calm and well managed.
- Emergency plans and evacuation procedures were in place. Staff were trained in how to respond to major incidents.
- There was a bed management system to ensure patients' needs were met when there was an increased demand on beds. If a patient could not be placed on a medical ward they would be cared for on a surgical ward.

Are medical care services effective?

Requires improvement

Care was provided in line with national best practice guidelines. Clinical audit was being undertaken and there was good participation in national and local audit that demonstrated good outcomes for patients. We observed good clinical practice by clinicians during our inspection.

Nursing and medical handovers provided evidence that key issues in patient care were being handed over and acted on. Senior clinical staff gave clear direction and support to junior staff to ensure patients received appropriate care.

Patient morbidity and mortality outcomes were broadly within what would be expected for a hospital of this size and complexity. Specialist surveys tended to indicate that performance is slightly below the average.

Medical care

Clinical staff were well trained, appraised, supervised and supported in delivering high quality care for patients.

However, significantly, there was no acute oncology service at this trust. This means that cancer patients are always referred to other hospitals for treatment. This can have an impact on the quality of patient outcomes.

Evidence-based care and treatment

- The medical division adhered to National Institute for Health and Care Excellence (NICE) guidelines for the treatment of patients. The trust has an effective process to monitor the implementation of NICE guidance. Data provided by the trust indicated that it is in the process of implementing new guidance on arrhythmias (relating to heart failure) and the use of canagliflozin (type 2 diabetes drug) in treating diabetes.
- There are national operational standards to ensure that 90% of admitted patients start consultant-led treatment within 18 weeks of referral. The trust performs very well in this area, and often achieves 100% performance in a number of clinical specialties.
- Local policies such as the pressure ulcer prevention and management policy were written in line with national guidelines, and staff we spoke with were aware of these policies.
- NICE and trust guidelines were available on the trust intranet. Staff told us that guidance was easy to access, comprehensive and clear.
- Doctors told us that the trust had a good programme of clinical audits and that staff were encouraged to attend presentations on audit outcomes. Staff were also encouraged to undertake their own audits. We spoke to a doctor, who was very positive about the audit process, and who said that he was undertaking an audit on oxygen usage.

Pain relief

- We observed staff monitoring the pain levels of patients and recording the information. Pain levels were scored using the NEWS chart.
- Patients we spoke with told us they were given pain relief when they needed it.

Nutrition and hydration

- Patients' nutrition and hydration status was assessed and recorded on all the medical wards.
- All patients had drinks in reach. Care support staff checked that regular drinks were taken where required.
- The patients we spoke with told us they were always given choices of food and snacks. Patients were positive about the quantity and quality of the food they received in the hospital. One patient told us: "It's fine, I have no complaints, there is always something I like on the menu."
- A red tray system (to alert specialist nutrition nurses) was used on all medical wards to identify patients who needed help with eating and drinking. We observed three meal times and noted that support was given appropriately to patients who needed it.

Patient outcomes

- The hospital's mortality rates were within expected range.
- The trust performance in the national sentinel stroke audit had deteriorated its previous high level to level C between October/December 2013 and January/March 2014. This was still above average. The trust performed well in scanning, but poorly in physiotherapy and speech and language therapy.
- The trust's performance in the 2012/2013 heart failure audit was worse than the national average. It scored worse than average for 6 out of 11 indicators.
- The trust performance in the National Diabetes Inpatient Audit (NaDIA) 2013 was worse than expected for 12 of the 21 indicators, which included: visit by a specialist team; food risk assessment during stay; and overall satisfaction. Seven indicators were better than expected when compared to the England average, which included insulin error and staff awareness of diabetes.

Competent staff

- Clinical staff told us they had regular annual appraisals. Staff however, were supervised clinically and felt that handovers, ward rounds and board rounds provided them with learning opportunities.
- Data provided by the trust showed that by August 2014 84.4% of staff in the medical division had completed an appraisal against a trust target of 90%.
- The dementia training lead for the trust told us that there were three levels of training in this area. Trust information showed that: 84% of all staff had been trained to level 1 against a target of 80%; 74% of junior doctors had been trained to level 2 against a target of 80%; and 54% of appropriate staff had been trained to level 3 against a target of 50%.

Medical care

- We found a great deal of confusion among many staff about which dementia training they should have received, and which training they had already completed. Some staff said they covered it for an hour during their induction programme, while others said they had spent a whole day on dementia training during induction. None of the staff we spoke to were able to describe what the three levels of training were and who they were suitable for.
- Trainee doctors we spoke to said they were well supported and the hospital was a safe place to work. Teaching was supported and changes to guidelines were cascaded.
- The nursing handovers, which we observed, included a discussion of each patient and their progress and any potential concerns.

Multidisciplinary working

- Throughout our inspection we saw evidence of multidisciplinary team (MDT) working in the ward areas. Doctors and nursing staff told us nurses and doctors worked well together in the medical speciality.
- MDT meetings took place once or twice a week depending on the ward. Staff told us that the meetings were effective and well supported by health professionals that included: nurses; physiotherapist; occupational therapist; speech and language therapist; and discharge liaison team. The discussions at this meeting were patient-centred and actions plans were completed following the discussions.
- Patients' records showed they were referred, assessed and reviewed by physiotherapists, dieticians and the pain team.
- We spoke to a number of physiotherapists who told us that they felt a full part of the team caring for the patient. They said that patients were appropriately referred to them by other professionals.
- Patients in the CCU were waiting too long to receive an echocardiogram to support diagnosis. Staff and the manager told us that patients often had to wait up to five days. Managers told us that they were aware of the issue, and were in the process of recruiting additional staff.
- The pharmacy support available for the medical wards was stretched. Although the pharmacy is available seven days-a-week, there were not always enough pharmacists on duty. We found examples where patients were sent home without their medication, which had to be sent on later or had to be collected from the hospital pharmacy later.
- Staff on the medical wards worked in close liaison with discharge co-ordinators and hospital and local authority social work teams.
- The trust has a limited acute oncology service. This can have an impact on the quality of patient outcomes.

Seven-day services

- There was a consultant presence on the medical wards seven days-a-week. Patients admitted at night were either seen by the on-call consultant or by medical consultants the next morning. All new patients were seen by the on-call consultant within 12 hours of admission.
- On all the other wards we visited a consultant ward round took place twice a week. The patients were seen by junior doctors on the other days.
- Staff told us consultants were on-call out-of-hours and were accessible when required.
- The pharmacy department was open seven days-a-week, but with limited hours on Saturday and Sunday. There were pharmacists on-call out-of-hours to provide advice to staff on duty.
- Support from the psychiatry liaison team was available over the weekend.

Are medical care services caring?

Good

Patients received compassionate care and patients were treated with dignity and respect. Staff were focused on the needs of patients and improving services for patients.

Most patients and relatives we spoke with said they felt involved in their care and were complimentary and full of praise for the staff looking after them. One person told us: "The staff are very good indeed, they can't do enough for you, to be quite honest, even the doctors I see are good."

Patients on Osterley Two ward raised concerns about the care they were receiving. One person told us: "They don't

seem to care about the wellbeing of the patient because nobody has ever taught them to do so." Another said: "They (the staff) chat at 10-to-the-dozen throughout the night, and not at normal voice either, they're quite loud."

There were patient and carer support groups associated with the hospital. These included the diabetes support group and the Upbeat Heart Group that supported people with heart conditions.

Compassionate care

- Results of the Friends and Family Test (FFT) were displayed on every ward, and there were posters displayed encouraging patient feedback so that they could improve the care provided. Overall these showed satisfaction with the service provided.
- The trust has an FFT response rate of 37% compared to a national average of 30%. The CCU score is consistently above the national average for positive responses. Most other wards are scoring consistently slightly below the national average.
- Throughout our inspection, we observed patients being treated with compassion, dignity and respect. We saw that call bells were answered in a timely manner. Curtains were drawn and privacy was respected when staff were supporting patients by providing personal care.
- The patients and relatives we spoke with were pleased with the care provided. They told us doctors, nurses and healthcare assistants were generally caring, compassionate and responded quickly to their needs. One patient told us: "If you say there's a problem they immediately call a nurse." Another said: "The staff are very good indeed, they can't do enough for you, to be quite honest, even the doctors I see are good."
- Patients on Osterley Two ward raised concerns about the care they were receiving. One person told us:, "They don't seem to care about the wellbeing of the patient, because nobody has ever taught them to do so." Another said: "They (the staff) chat at 10-to-the-dozen throughout the night, and not at normal voice either, they're quite loud."
- We observed three poor interactions between doctors and patients. One doctor we observed on an elderly care ward spent only a few minutes with a patient telling them that they would need to go into a care home. The doctor did not empathise with the patient, ask them how they felt or what their view was. On another occasion we saw a doctor speaking to a patient in a very patronising way because the patient expressed concern that her pain was not under control.
- Comfort rounds or intentional rounding (where nursing and healthcare assistant staff regularly check on patients every two hours) were undertaken. Staff did various checks on patients such as: comfort checks; hydration; nutrition; continence; equipment; positioning; mobility; and skin survey. Medical records we looked at during our inspection confirmed that regular patient comfort rounds were being undertaken.

Patient understanding and involvement

- Patients and relatives we spoke with stated they felt involved in their care. They had been given the opportunity to speak with their allocated consultant.
- Patients told us the doctors had explained their diagnosis and that they were aware of what was happening with their care. None of the patients we spoke with had any concerns in regards to the way they had been spoken to. All were very complimentary about the way in which they had been treated.
- We observed nurses, doctors and therapists introducing themselves to patients at all times, and explaining to patients and their relatives about the care and treatment options.
- Some patients and families told us that staff did not always tell them what was going on with their treatment.

Emotional support

- There were patient and carer support groups at the hospital such as a diabetes support group and the Upbeat Heart Group that supports people with heart conditions.
- The Mulberry Centre at the hospital provides a quiet non-clinical area where patients diagnosed with cancer can obtain information and support.
- The multi-faith service covered a range of faiths including: Anglican; Catholic; Free Church; Jewish; and Muslim. The service was available to provide patients and their families with emotional support. Representatives of other faiths could be contacted if required.

Medical care

- We found a very few number of patients wearing their own bed clothes, but the majority were wearing hospital gowns. Wearing your own clothes can be very comforting for people and can provide some familiarity for people living with dementia.

Are medical care services responsive?

Good

The AEC is effective in reducing the number of inpatient admissions and managing the increasing number of patients that require emergency admission following referral from a range of sources, which include direct referral from GPs.

The hospital admitted a high number of medical patients from A&E, which this means that flow is unpredictable. Senior staff told us that in the last 12 months the daily medical take (admissions) had gone from about 35 to about 50.

The trust had recently opened a redesigned dementia friendly ward and had introduced the Reach out to me booklet for patients living with dementia developed to alert and inform staff to identify and meet the needs of these patients. The booklets were well-designed, but during our inspection we found only four examples where they had been completed. More importantly, only one member of staff we spoke to (a senior nurse) could describe the differences using the Butterfly Scheme (an organisation that provides training and templates for hospitals to use with people living with dementia) or the booklet would make to the patient.

The trust has a policy of reviewing all emergency admission over the age 75 within 72 hours to assess if they were living with dementia or suffering delirium. We examined 35 sets of medical notes for patients over 75 years–of-age, and who had been in the hospital for more than 72 hours. We found that there were yellow stickers in 27 sets of notes.

Staff were very positive about the on-site psychiatric liaison team. The presence of the team seven days-a-week means that assessment, support and treatment were not delayed for people living with psychiatric conditions.

Where patient experiences were identified as being poor, action was taken to improve this. Patient groups we spoke to told us that the trust is willing to listen to concerns and make changes when appropriate.

We found that there was a low level of understanding of the needs of patients living with learning disabilities. Very few staff we had spoken to had had specific training in this area.

Service planning and delivery to meet the needs of local people

- The AEC aimed to prevent avoidable, emergency inpatient admissions by managing the increasing number of patients transferred by a range of sources that includes direct referral from GPs. There were consultant-led assessment clinics and a range of services provided such as intravenous antibiotic treatment and blood transfusion for patients who required treatment but not hospital admission.
- AEC patients were very positive about the care and treatment they received. One person told us: “It’s much better than waiting in A&E, they have more time to look after me properly here.”
- Managers told us that they were aware that alcohol was one of the causes for medical admission to the hospital. To meet this need, the trust had alcohol support services and worked with community partners to provide patients with long-term solutions.

Access and flow

- The hospital admitted a high number of emergency medical patients from A&E, which meant that flow was unpredictable. Senior staff told us that in the last 12 months the daily medical take (admissions) had gone from about 35 to about 50.
- There was a trust-wide operational group responsible for the co-ordination of capacity and bed availability. It liaised daily with individual wards to establish the numbers of patients on each ward and how many beds were available for new admissions. They also discussed any action that was required when wards were at full capacity
- Senior managers told us that there were difficulties in finding suitable community-based facilities for patients. For example, stroke patients only need to spend about 21 days in hospital before moving to a lower dependency environment in the community. However,

because rehabilitation places were not always available patients sometimes spend longer at the hospital. For patients nearing the end of their lives, there is limited hospice capacity in the area.

Meeting people's individual needs

- The trust has a policy of reviewing all emergency admission over the age 75 within 72 hours to assess if they were living with dementia or suffering delirium. We examined 35 sets of medical notes for patients over 75 years–of-age, and who had been in the hospital for more than 72 hours. We found that there were yellow stickers in 27 sets of notes.
- The trust had recently opened a redesigned ward specifically to meet the needs of patients living with dementia to promote calm well-being. It had recently introduced the Reach out to me booklet for patients living with dementia developed to alert and inform staff to identify and meet the needs of these patients. The booklets were well-designed, but during our inspection we found only four examples where they had been completed. More importantly, only one member of staff we spoke to (a senior nurse) could describe the differences using the Butterfly Scheme (an organisation that provides training and templates for hospitals to use with people living with dementia) or the booklet would make to the patient.
- The trust also used the Butterfly System to identify people living with dementia and so ensure they receive care specific to their needs. We found some notes with butterfly stickers on them but then did not always find the butterfly sign over the person's bed.
- Trust managers told us there was an Older Adults Specialist Intervention Service (Oasis), which is a small team, designed to offer advice and support to staff. Staff we spoke to had mixed views about the team. Some were very positive about their contribution while others were not sure about the team's role.
- Staff were very positive about the on-site psychiatric liaison team. The presence of the team seven days-a-week means that assessment, support and treatment were not delayed for people living with psychiatric conditions.
- Staff were unclear about the assessment process, and a number told us they thought the age for assessment was 65 years. On one set of notes we found the yellow sticker was blank except for the words "patient does not speak English". When we spoke to staff about this they were unable to explain why the patient had not been assisted with an interpreter or family member.
- We found that there was a low level of understanding of the needs of patients living with learning disabilities. Very few staff we spoke to had had specific training. We spoke to the relatives of a person with living with learning disabilities, who was a patient at the hospital. They told us: "They just don't seem to understand her needs and how to communicate with her, and they don't listen to us." One senior nurse told us: "I had an input for an hour on it, but we really need more training in the area."

Learning from complaints and concerns

- Staff told us that they did their best to deal with issues and complaints at a ward level.
- More formal complaints were handled in line with the trust's policy. Staff directed patients to the Patient Advice and Liaison Service (PALS) if they were unable to deal with their concerns directly and advised them to make a formal complaint. Patients we spoke with felt they would know how to complain to the hospital if they needed to.
- Where patient experiences were identified as being poor, action was taken to improve this. For example, the patience experience board raised the issue that the front of the hospital was untidy because smokers discarded their 'butts' on the ground. As a result, the trust implemented an action plan to improve the situation.
- Patient groups we spoke to told us that the trust is willing to listen to concerns and make changes when appropriate. They also said that the trust was candid about its mistakes.

Are medical care services well-led?

Good

The medical division was well led, and managers had a clear understanding of the key risks and issues in their area. They had clear processes to identify performance

concerns and had plans to improve performance and keep patients safe. They were also committed to making stronger links with community services to ensure appropriate care was provided on discharge.

Ward staff felt well supported by their ward sisters and matrons, and they told us they could raise concerns with them. Staff told us that they regularly saw divisional managers and clinical leads on the wards. Other than the director of nursing, members of the board did not have a high visibility on the wards.

Ward managers and ward sisters were passionate about improving services for patients and delivering a high quality service. Staff spoke positively about the high quality care and services they provide for patients and were proud to work for the trust. They described the trust as a good place to work and that it had a supportive culture. The most consistent comment we received was that the trust was a friendly place and people enjoyed working there.

Vision and strategy for this service

- The trust's vision of "a first class hospital for our community" was well recognised and owned by staff.
- The medical division had short, medium and long-term strategies. We found that priorities were identified to improve services across medical division. The medical division leads told us their priorities included ensuring sufficient staffing levels, improving patient pathways with other hospitals and making treatment even safer. They were also committed to making stronger links with community services to ensure appropriate care was provided on discharge, particularly for patients with long-term conditions such as stroke and complex frail elderly patients.
- The medical leads stated they aimed to improve seven-day working service across the medical division. However, there were concerns about whether the hospital was big enough in scale to achieve this.

Governance, risk management and quality measurement

- The wards we visited had regular team meetings at which performance issues, concerns and complaints were discussed. Where staff were unable to attend ward meetings, steps were taken to communicate key messages to them.
- The medical division had a monthly scorecard that looked at key areas of performance: assessment and treatment times; training performance; staff information such as sickness rates. It showed how the services performed against quality and performance targets. The ward areas did not have any visible information about the quality dashboard except for the staffing levels and the Safety Thermometer, which were displayed at the entrance of each ward.
- The medical division had monthly clinical governance meetings where the results from clinical audit, incidents complaints and patient feedback were shared with staff. Clinical governance systems were effective and staff explained how this had an impact on patient care.
- The medical division had a risk register where risks were documented, and a record was maintained with the action taken to reduce the level of risk.

Leadership of service

- Ward staff felt well supported by their ward sisters and matrons, and told us they could raise concerns with them. Staff told us that they regularly saw divisional managers and clinical leads on the wards. Other than the director of nursing, members of the board did not have a high visibility on the wards.
- We spoke to the divisional managers who had a good understanding of the issues in their clinical area. For example, they were aware that the trust performance in starting treatment for cancer patients within 62 days had been poor. They had analysed the problem and undertook activity to improve performance. This had reduced the number of cancer cases starting treatment later than the 62-day-target from 100 in July 2014 to 20 cases at the time of our inspection.
- Leadership around supporting people with living dementia was unclear. There was a lack of co-ordination between the nursing, medical and training leads.
- Junior doctors felt well supported by consultants and senior colleagues. Medical staff felt supported by the medical leadership in the division and the trust.
- Student nurses told us they felt supported on the ward and received supervision and training from the senior staff. They told us consultants were accessible and approachable.
- We observed good leadership skills during medical and nursing handovers. Senior staff were visible in leading these meetings and giving clear direction and support to junior colleagues.

Medical care

Culture within the service

- Ward managers and ward sisters were passionate about improving services for patients and providing a high quality service. However, staff across the division felt the trust's senior managers were not always receptive to the concerns they raised.
- Staff spoke positively about the high quality care and services they provided for patients and were proud to work for the trust. They described the trust as a good place to work and as having an open culture. The most consistent comment we received was that the trust was a friendly place and people enjoyed working there.

Public and staff engagement

- Patients were engaged through feedback from the NHS FFT and complaints and concerns. Clinical governance meetings showed patient experience data was reviewed and monitored.
- The chief executive chairs the patient experience board, and talks directly with patients and their representatives. Board meetings usually start with a video of a patient describing the experience of care they experienced in the trust.
- Staff engagement with the trust future strategy had not occurred. Staff told us that they did not know what the plans were for the trust in the future, and in particular the plans for amalgamation with other trusts.

Innovation, improvement and sustainability

- Innovation was encouraged from all staff members. Staff said that new ideas and analysis of the way things were done was positively encouraged by managers.
- The trust runs an innovative heads-up: what happened yesterday process, which provides a structured approach during staff handovers to ensure safety concerns are identified and dealt with at an early stage. Staff use a form to record what the concern was, what has been done and what still needs to be done to reduce the risk and ensure learning is implemented. Staff we spoke to were all aware of the scheme and were very positive about it.
- The new AEC has made an impact on both A&E performance and on reducing the number of admissions. More importantly, patients we spoke to were very positive about the care they received.
- The trust regularly urges patients and family members that raise concerns with the trust to record their experiences on video. Their experiences are then played to staff meetings to encourage greater empathy for the perspective of the patient.

Surgery

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

Information about the service

West Middlesex University Hospital NHS Trust provides elective and emergency surgery mostly to people in the London boroughs of Hounslow and Richmond. The surgery division provides day surgery and inpatient and emergency surgical treatment for adults and children. In 2013/14 55% of surgical procedures operations were day cases, 31% emergency and 13% elective cases with inpatient stay. The majority of procedures were in the specialities of: general surgery (breast, colorectal and urology: 30%); trauma and orthopaedics (treating acute injuries and conditions of the bones and joints: 27%); and ear, nose and throat (13%).

There are nine theatres. One is dedicated to emergency surgery and one to children's surgery. Two other theatres are specifically for orthopaedics and have a clean air enclosure. There are 16 recovery beds, including three dedicated paediatric beds. There are 76 inpatient surgical beds for adults that include a short-stay ward normally staffed for 16 patients overnight during the week, and 10 overnight at weekends. The West London day surgery centre has its own waiting and discharge area that is open until 8pm.

We inspected theatres, anaesthetic rooms and recovery areas, the day case unit and the post-surgical wards. We also visited the endoscopy unit, interventional radiology services and the pre-operative assessment unit. We spoke with seven patients, four relatives and 50 members of staff at different grades. Staff included: doctors; nurses, allied health professionals; ward managers; porters; cleaners; and administrative staff. We reviewed patient records and observed care being delivered in theatres and on the wards. We also received comments from our listening event, and reviewed performance information about the trust.

Surgery

Summary of findings

While we rated both safety and caring as good in surgery, the overall rating is requires improvement. This was because we had concerns about the timeliness of some surgery, the level of senior clinical consultant input and lack of planning to meet continuing increased demand for surgery.

There were enough staff on wards and in theatres, and staff told us they received appropriate training. Ward managers regularly reviewed the skills mix on their wards. Theatres had systems to maintain patient safety, which included team briefs and the World Health Organization (WHO) theatre checklist.

Consultants only undertook ward rounds on 3 out of every 7 days.

While there was evidence of good outcomes for many patients who underwent surgery, the hospital was not meeting the needs of some fracture patients as effectively as other hospitals. The time to treatment for hip fractures was lower than recommended by national guidelines, which led to longer hospital stays for some elderly patients. Patients returning home between diagnosis of fracture and surgery waited longer than recommended optimum times for treatment. There were limited out-of-hours services over weekends, and a lack of senior clinical cover at these times.

Patients spoke positively about their care and treatment at the hospital. They told us staff were caring, compassionate and professional, and we observed good care taking place. Surgical services were responsive to the needs of most patients. Patients were cared for in single sex bays to provide privacy and dignity. There was written information for patients about a range of conditions and procedures, and discharge information with details of who to contact, if necessary, when they were home. The service was responsive to the needs of people living with dementia.

Most patients considered the surgical services were responsive to their needs, but we had concerns about the number of patients not cared for in speciality beds, and lack of pace in investigating and learning from incidents.

There was no shared vision for surgery at the hospital, and we observed that staff in sub-specialities often worked in isolation, unaware of concerns that others were working on. The interface and the communication between trust administrative staff and senior clinical staff in surgery appeared to be poor. However, at ward level we saw good leadership and enthusiastic staff.

Surgery

Are surgery services safe?

Requires improvement

The surgery division learned from incidents, and there were appropriate policies and procedures to keep people safe. In theatres, staff were using a modified WHO Surgical Safety Checklist, and were working on embedding this after making changes to address points identified from audits.

Ward areas were adequately staffed and patient dependency was monitored to ensure wards had the right staffing levels and mix of skills. We saw proactive initiatives on the wards to reduce the numbers of falls and reduce the incidence of pressure ulcers that had been an issue earlier in the year.

However consultants undertake ward rounds on only 3 days per week. The surgery division had fewer consultants and more junior doctors than the England average. The number of orthopaedic surgeons was lower than recommended by the British Orthopaedic Association in relation to the size of population served, which was reflected in some delays to treatment in that speciality. The service was delivered by middle-grade doctors rather than by consultants, whereas best practice would be to have a consultant-led and delivered service.

Theatres scored less highly than wards on training compliance and record keeping, which had resulted from a long period of management instability.

Incidents

- There was a process for investigating Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measure are taken) and patient safety incidents, which included serious incidents that required investigation. There had been 12 serious incidents in the previous year of which nine related to grade three pressure ulcers, which was a high number. Effective steps had been taken to reduce the incidence of pressure ulcers. The surgery division had not had any Never Events in the past year. There had only been two serious incidents reported in the year to date.
- The staff we spoke with in theatres and surgical wards had access to the electronic incident reporting system, which most staff said was easy to use. They had been trained in incident reporting. However, we were told some incidents were raised informally rather than being formally registered on the system. The process for closing incidents was quite slow. In December 2014 the division had 222 outstanding incidents on Datix, of which 158 were waiting the start of a review, and 127 of these incidents occurred in theatre or recovery.
- Staff told us feedback from incidents reported electronically had been problematic for a few months because of an IT problem, but this had recently been rectified. Feedback on incidents was discussed at staff meetings. We saw minutes of these meetings.
- Incidents reported in the surgery division were predominantly clinical, but most caused little or no harm to patients. Following some serious incidents where patients had developed grade three or four pressure ulcers there had been a proactive response from staff, which involved training, more effective patient risk assessment and involvement of the tissue viability team. This had reduced the incidence of pressure ulcers by nearly two-thirds.
- Monthly divisional mortality and morbidity meetings reported to a trust-wide mortality review meeting. Each sub-speciality did its own report. Meetings were now recorded using a trust-wide template for the surgery division that identified lessons and actions with a named person responsible. This process was relatively new and it was too early to judge how effective it is to ensure lesson are learnt to prevent recurrence of similar events.

?

Safety thermometer

- The NHS Safety Thermometer is a national improvement tool for measuring, monitoring and analysing patient harms and 'harm-free' care. The tool includes information about patient falls, catheter and urinary tract infections, new venous thromboembolism and incidence of pressure sores. Ward staff monitored patient care in line with this tool. Safety Thermometer information was clearly displayed on each surgical ward, as well as discussed at ward and divisional meetings.
- A Skin Bundle (a pressure ulcer prevention initiative) and Waterlow assessment (pressure ulcer risk assessment/prevention policy tool) were used on the surgical wards, and new mattresses had been obtained to reduce the risk of pressure sores. Urinary care

bundles were used to reduce infections from catheter use and patients were provided with non-slip slippers to reduce the risk of falls. Statistics from September showed a significant downward trend in the incidence of ulcers and falls since April 2014.

Cleanliness, infection control and hygiene

- We found local and national guidance for infection control was being followed at the trust.
- We inspected surgical ward areas, pre-assessment rooms and operating theatres. The cleaning service was contracted out and the standard of cleanliness and tidiness was good. Regular audits of infection control standards were carried out and results were displayed on wards. The scores were consistently high. Wards also displayed the number of days since infection by MRSA and Clostridium difficile**.**
- Clinically clean stickers were used to demonstrate when items had been cleaned by ward staff.
- Staff were up–to-date on hand hygiene training and we observed staff washing their hands before and after patient contact. They followed bare below the elbow guidance in line with infection and prevention control guidelines. We observed good examples of barrier nursing.
- An infection prevention and control care pathway was in use for every surgical patient. The infection prevention and control (IPC) team had not expressed concerns about theatre hygiene to the theatre manager who had attended their meetings, although actions to initiate IPC training had not been taken.
- There was a link nurse for infection control in theatres, but there had been no recent IPC training in theatres and theatre staff had not carried out regular hand hygiene audits.
- The hospital performed well in the national data for Orthopaedic Surgical Site Infection. No hospital-acquired infections had been reported in surgical patients in the previous three months.
- Several staff mentioned there were not enough side rooms in the hospital, which sometimes meant medical patients that needed isolation had to be accommodated on surgical wards.
- We inspected the on-site sterile services unit. This contracted-out service was responsible for the dispatch and receipt of instruments, repairs and replacements, and managed the loan of orthopaedic sets for hip and knee procedures. It was well managed and had appropriate certification relating to quality management and traceability of surgical instruments and evidence of recent external audit.

Environment and equipment

- The theatres were well laid out so staff could work safely and efficiently. There was an external contract for maintaining theatre equipment. We checked a sample of equipment and noted service dates and portable appliance (PAT) tests were up–to-date. The theatre manager had no formal communication links with either of the two contractors about service arrangements.
- The wards were bright and clean, although storage space was limited.
- Sufficient ancillary equipment was available such as wipes, gels and sharps bins.
- The endoscopy unit had achieved accreditation from the Joint Advisory Group on Gastrointestinal Endoscopy. However, the space was inadequate for the demand and flow of patients. There was only one toilet in each of the male and female waiting rooms, and shortage of storage space had led to equipment being stored in the treatment room, which made it difficult to clean. We were told the service was due to move into new premises as part of the planned expansion of the regional bowel cancer screening programme.
- We checked resuscitation equipment and defibrillators in surgical wards and theatres and saw they were checked daily and ready for use.
- We noted sporadic recording of anaesthetic machine checks. We were told some anaesthetists recorded these checks on individual patients' anaesthetic charts, but we were not able to verify this.

Medicines

- On the surgical wards medicines were stored correctly and safely. The only exception was on one ward where intravenous drugs were kept in a cupboard without a lock. Controlled drugs were checked daily by two staff members. We observed this being done. Drug fridge temperatures were checked daily and audited on the wards, but not in the theatre area.
- The medicine trolleys on the wards were locked and secured to the wall when not in use. Pharmacy topped up supplies twice weekly. There were daily ward visits by pharmacists to complete medicines reconciliation.
- Medication incidents were reported and audited.

- Nurses and patients mentioned delays in dispensing take-home medicines. Some patients had to collect these after discharge.

Records

- Patients had their care needs risk-assessed on admission. We checked 12 sets of records across the three surgical wards. All patients had had an initial assessment including the reason for admission. Risk assessments had been carried out and all observations were properly completed, were up-to-date and had been properly completed and signed.
- In response to past errors in completing the fluid balance charts, the form had been redesigned to ensure a patient's own fluid intake was recorded as well as output and intravenous fluids.
- When we checked the theatre register for frequency of certain procedures we noted that there was no data recorded for several different time periods.

Safeguarding

- There were systems for staff to report safeguarding concerns. Staff were aware of the process and could explain what was meant by neglect or abuse. A spreadsheet showed 90% of nursing staff on wards had completed adult safeguarding training to level 2. Members of staff were able to explain the process for raising a concern. However, in theatres only 45% of staff appeared to have completed Safeguarding Level 2 updates.

Mandatory training

- Statutory and mandatory training updates were overall 15% to 20% below trust targets. The division aimed to raise the training performance to become compliant by the end of December 2014. Training compliance was weakest in theatres and anaesthetics.
- We noted a particularly low training uptake for updates on basic and intermediate life support and safeguarding in theatres. Fewer than 45% of theatre staff had completed these updates.

Management of deteriorating patients

- WHO checklists had been audited twice since 2013. Changes had been made as a result, such as the introduction of a stamp for anaesthetists to use to identify them more clearly. Our observation of practice indicated that the initial briefing was not taking place consistently, and the process was rather formal. The period without a theatre manager had led to slippage in recording standards. While this did not appear to have impacted on patient safety, the new manager had reintroduced compliance monitoring and reporting processes.
- A WHO checklist audit carried out in September 2014 showed checklist sign in had been fully completed in 80% of instances meaning that one in five were not. Compliance in individual sections of the checklist under time out and sign out varied with none at 100%.
- For patients in recovery after surgery there were specific patient checks in addition to the National Early Warning Score (NEWS). Patient checks included Sepsis Six (actions to double a patient's chance of surviving sepsis if carried out immediately) nausea scores, pain and sedation. Patients had to meet set criteria in terms of nursing observations before leaving recovery.
- The surgical wards used NEWS to assess the severity of acute illness. We saw appropriately maintained observations on patient files, with escalation recorded as appropriate. Staff on surgical wards were able to explain the escalation process in the event of a clinical emergency. They knew where to find emergency equipment and what steps to take

Nursing staffing

- There was a low level of staff vacancies in theatres. Bank staff (staff who work overtime in the trust) were used rather than agency staff as far as possible in theatres. However, the theatre staff establishment was insufficient for the workload. Statistics showed that there were extra sessions every week to keep up with demand and meet targets. Theatres were carrying out 10% to 15% more procedures than planned. For example the impact on staffing meant that there were 10 extra agency staff working to an equivalent full-time level in the week beginning 17 November 2014.
- Surgical wards had adequate staffing, both night and day during our inspection. The skills mix met the Royal College of Nursing (RCN) recommended mix of at least 65% registered nurses to healthcare assistants, and we were told there was scope to increase staffing if there was a high level of need among patients.
- Some bank and agency staff were used at night, but we were assured there was always one permanent nurse on duty. We were told about induction procedures for agency and locum staff, but saw that reported compliance with this in the surgery division was only 58%.

- The vacancy rate had reduced from 9.8% early in 2014 to 5.9% at the time of our inspection. A number of nurses had been recruited from overseas to help reduce the reliance on agency staff.
- Doctors reported a shortage of clinical nurse specialists for colorectal and stoma care. In the latter speciality there was only one part-time stoma care nurse for 120 patients a year.
- Healthcare assistants had a one-week induction that included pressure ulcer care.

Medical staffing

- The surgery division had fewer consultants and more junior doctors than the England average. The number of orthopaedic surgeons was lower than recommended by the British Orthopaedic Association in relation to the size of population served, which was reflected in some delays to treatment in that speciality. The service was delivered by middle-grade doctors rather than by consultants, whereas best practice would be to have a consultant-led and delivered service.
- There were junior doctors ward rounds daily during the week, and a daily consultant post theatre ward round.
- There was always a surgical and an anaesthetic consultant on call. Consultant on-call cover was changed by the day, which meant that a patient might be the responsibility of different consultants on subsequent days. Staff suggested that a surgical consultant of the week with no other duties would further improve continuity for patients and for the staff caring for them.
- There was limited out-of-hours senior cover. A surgical registrar (or equivalent) was on call from 8am to 8am but did not generally stay in the hospital after 10pm. This doctor supported a senior house officer surgical doctor, who was resident overnight.
- Many surgery sessions were not led by consultants. Trauma and orthopaedic emergencies were mainly covered by middle-grade doctors.
- An additional locum consultant had been brought in to help the hospital address waiting times for elective surgery. But, there were too few consultants to offer consultant-led care for most patients, and insufficient surgeons to meet demand in a timely way.
- The newly introduced Hospital at Night scheme was considered helpful in managing junior doctors' workload more effectively at night.

Major incident awareness and training

- There was a documented business continuity plan that identified key risks, which could affect the provision of care and treatment following an internal or external event. We were told there was no specific policy for theatres and that staff followed trust guidelines.
- There were clear instructions for staff to follow in the event of a fire. Surgical ward staff were aware of the policy.

Ward and medical handovers

- We observed a morning surgical ward briefing that involved all staff and therapists. This was well attended and actions were clear. We also observed an operating department practitioner collecting a patient from the admissions ward, and later the admissions ward receiving the patient from theatre recovery. All relevant checks were made at each handover.
- We attended an orthopaedic surgeon's handover and teaching session as well as a general surgery handover reviewing the previous night's admissions. Time for the latter was constrained because it took place in a clinic waiting area before the start of the clinic. Designated areas for surgical handovers would ensure confidentiality and allow retention staff to stay longer for some on-the-spot teaching

Are surgery services effective?

Requires improvement 

Outcomes for patients who had undergone elective surgery for bowel and lung cancer were close to or better than the England average. The trust took part in national and local clinical audits and staff used care pathways effectively. Not all national and local audits were completed, and some recent audits did not have associated action plans or plans to check whether performance was improving.

Pain relief was well managed and patients' nutritional needs were catered for.

Many procedures and treatments in surgical services were reviewed against national clinical guidelines.

Evidence-based care and treatment

- National Institute for Health and Care Excellence (NICE) guidelines were used in many areas such as in pre-assessment processes. Clinical staff in theatre

followed NICE guidance for the assessment of venous thromboembolism, inadvertent perioperative hypothermia and pressure ulcers and in the use of protective equipment. The new theatre manager was setting up a team to review all policies and procedures in theatre in line with NICE and medical royal college guidelines. Policies we looked at were generally in date, referenced and signed off.

- Surgical teams were asked by the central audit team to monitor compliance with new NICE guidelines and alerts from Central Alerting System. Although reports were made to the clinical effectiveness and standards committee, surgery division attendance at these meetings appeared rather sporadic and clinicians did not often send deputies.
- Nursing staff were able to describe the process for keeping up-to-date with new guidance. A practice facilitator provided support to nurses.
- The trust participated in some national clinical audits such as hip fracture, bowel cancer, lung cancer and head and neck oncology. A number of local audits were also undertaken, although more local audits appeared to have been registered with the trust central team than had been completed. Some audits had associated action plans, but there was not a clear re-audit strategy to ensure practice was improving.
- There was no all-day list for emergency surgery, and surgeons told us that elective surgery took precedence over emergencies. Best practice according to Royal College of Surgeons of England standards for unscheduled surgical care would have a dedicated separate team for emergencies 24/7. More rapid treatment of patients that require emergency surgery could reduce mortality, complications, length of hospital stay and a provide a more positive experience for patients.

Pain relief

- The trust had a specialist pain team that provided direct support to staff in surgical wards. Pain tools were uses to assess pain as part of care pathways. A dedicated anaesthetist and nurse provided training for all staff on epidurals and patient-controlled pain relief (PCA).
- Ward nurses were trained in the main forms of pain control used on the surgical wards.
- We observed patients being asked about pain and staff responding

Nutrition and hydration

- Patient records included an assessment of their nutritional requirements. The Malnutrition Universal Screening Tool (MUST) was used to assess all patients. Patients said they had a choice of food and drink.
- Where patients had a poor nutritional intake, fluid and nutrition charts were used to help ensure they were adequately nourished and hydrated. A red tray system was used to alert staff to patients with nutritional needs or those that required help with eating. A magnetic sign also highlighted this above patients' beds.
- Protected mealtimes were observed and additional staff came to the ward to help with mealtimes.
- We noted that on some days patients were starved prior to surgery for longer than recommended in current guidelines, but staff did not feel empowered to raise concerns. Several staff mentioned to us that it was not uncommon for inpatients to be starved before procedures that were subsequently cancelled.

Patient outcomes

- In some areas the trust was behind national norms. For example, the trust had submitted an incomplete return for the National Emergency Laparotomy Audit 2014, which revealed only 14 out of 28 measures had been audited. We noted there was little consultant involvement in emergency surgery and reluctance to defer elective surgery to prioritise emergencies, which could be a risk to emergency patients.
- We also had concerns about the surgical pathway for children and adults with non-displaced fractures. Pressure on clinic time meant fracture clinic appointments, particularly when there were bank holidays, might be two weeks after the injury. This resulted in surgery inevitably falling outside the trust's 10 day protocol for treatment. From April 2014 three children had waited 13 to 19 days for surgery, and 23 adults had waited between 11 and 32 days. The delay was not good for patient experience and could lead to longer term costs for both patient and hospital. There was a plan to increase the number of trauma lists in existing budgets.
- The trust had a marginally higher than average rate of patient readmission to wards for urology, non-elective ENT and non-elective trauma and orthopaedics, but not theatre.

Surgery

- Performance in national audits demonstrated that outcomes for patients were within or better than the England average, particularly for bowel and lung cancer.
- All cancelled operations were rebooked and patients treated within 28 days, which was better than the England average.
- The Enhanced Recovery Programme (ERP) was used for suitable patients that had had one of the following elective procedures: total knee replacement; total hip replacement; vaginal or total abdominal hysterectomy; myomectomy or laparotomy. Suitable patients were identified at pre-operative assessment, and small group sessions were held each week to inform new patients about the process. Where patients required aids at home these were provided by hospital staff, who retained responsibility for ERP patients for six weeks.
- The trust was in line with the England average for Patient Reported Outcome Measures for knee and hip surgery.

Competent staff

- Newly qualified nursing staff had preceptorships (practical experience and training) to support and guide them in the first six months of their employment. Nurses said they had regular feedback from line managers.
- Training modules were available for more experienced nurses in topics such as tissue viability and colorectal care, and a number of staff had attended these. Trainee doctors and therapy staff said they had opportunities for further study.
- Appraisals had been completed for 78% of staff, against a trust target of 90%.
- Emergency cross cover (surgery by doctors outside their normal area of practice) was a potential risk to safe care. Trainees told us they did not have to perform procedures they did not feel competent to do and had access to registrar support by telephone, who was on-call for general surgery. On-site registrar or consultant support at night would reduce the risks associated with cross cover. The lack of senior cover at night was mentioned to us by senior staff, but was not on the surgical risk register.

Multidisciplinary working

- Multidisciplinary (MDT) team working was evident on the wards in supporting the planning and delivery of patient-centred care. There were daily ward meetings involving physiotherapists and occupational therapists, as well as nurses and doctors. Social workers and safeguarding staff could be involved as required. There was a weekly cancer MDT for general surgery.
- Staff spoke of effective support from the tissue viability service.
- Physiotherapists reported good working relationships with surgeons and with community physiotherapists when patients were discharged.
- Letters were sent to GPs after surgical procedures and clinic appointments, and copied to patients.

Seven-day services

- The percentage of discharges before midday had slipped from 16% the previous year to 10% in the last four months of 2014. We did not see a plan to improve timely discharge.
- The trust was aiming for full compliance with seven-day services by 2017/18 but was some way from providing this. Seven-day working did not seem to have the active support of all staff.
- Most surgical procedures carried out at weekends were emergencies. There was one on-call surgical team at weekends. There were sometimes scheduled theatre lists at weekends, including for complex surgery such as hip fracture. A registrar was usually present, but not generally a consultant. Although staff did not express concerns about this, it meant the service was not consultant-led.
- There was 24/7 x-ray and CT scanning, but there was no interventional radiology out-of-hours or at weekends. Radiologists worked a 12-hour day during the week. After this radiologists were on-call and we saw evidence of scans out-of-hours.
- Pathology was available on Saturday mornings and then on-call.
- Pharmacy services were available for four hours-a-day at weekends and then on-call. We were told that lack of drugs for patients to take home could delay discharge at weekends.
- Patients on enhanced recovery programmes received physiotherapy twice daily at weekends. However, there was limited therapy for other patients at the weekend unless a person's needs were urgent. This could restrict patients' progress with rehabilitation.
- In October 2014 some consultants had started Saturday morning ward rounds. There were no consultant ward

rounds on Sundays. Nurses reported that doctors' rounds were variable at weekends, particularly on Richmond ward that was mainly for short-stay surgical patients.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patient records showed staff sought informed consent from patients, which was recorded appropriately and correctly. There was documented evidence of pre-operative risk assessments, which included establishing informed consent by speaking to patients about the risks of anaesthetics and surgery. Audits showed that consent was not always taken by senior staff, and some consent was not obtained sufficiently far in advance. Action was being taken to address this and a re-audit was planned.
- Theatre staff we asked about consent were clear about its meaning. They were less familiar with the Mental Capacity Act and the implications of this to protect people's rights. By contrast, staff on the wards were more aware of patients' capacity to make decisions. When patients lacked capacity they asked for advice from professionals so decisions could be made in patients' best interests.
- We spoke to two staff on the wards about Deprivation of Liberty Safeguards. These staff demonstrated a good understanding of how this applied in their work.

Are surgery services caring?

Good

Feedback from patients and their relatives was generally positive. Staff interactions with patients were kind and courteous. Staff showed a caring approach. The NHS Friends and Family Test (FFT) scores were displayed on wards, but we did not see them proactively used to improve ward level experience.

There were processes to gain informed consent and involve patients and families in decisions about care. We saw patients' privacy and dignity were respected.

Compassionate care

- Throughout our inspection we observed good care of patients, and particularly for patients with dementia on surgical wards where we saw staff being patient and courteous.
- Patients we spoke with were positive about the care they received.
- The FFT results on whether patients would recommend the hospital to their friends and relatives were slightly lower than the average in England both in the proportion of people responding and the level of recommendation.

Patient understanding and involvement

- Patients said they knew who their named nurse was, but one patient said in practice their contact was mainly with a healthcare assistant.
- Patients knew the name of the consultant who had admitted them, but they were not necessarily aware of which doctor had performed their surgery.
- Patients we spoke with felt informed about their procedure, the expected outcome and post-operative issues. We observed that clear information was given to a patient before they were asked to sign a consent form.
- Relatives said they usually had the opportunity to speak to a doctor, but not necessarily to a consultant.

Emotional support

- Clinical nurse specialists were available to support for people with particular conditions, and those with severe pain. There was also access to support for different religions should patients or families need it.

Are surgery services responsive?

Requires improvement

Surgical services were not always responsive to the needs of patients. The trust was meeting most referral to treatment times and discharges were not significantly delayed, although no more than 10% of patients were discharged before midday. We noted that a number of people were discharged without medicines to take away. The division had been failing to meet commissioners' targets for timely discharge letters, although this had recently improved. However, a significant number of surgeons had opted to have their discharge letters sent

unverified to avoid delays. This meant that 43% of discharge letters were not verified. Staff were not clear about arrangements to monitor the error level in unverified letters.

There were not always enough beds on surgical wards, and a number of surgical patients were not cared for in speciality beds. We also saw medical patients on surgical wards, including the short-stay surgical ward, where figures showed that on average 20% of patients in the past year had been medical patients.

Services did not run seven-days-a-week, and theatre use was not optimised. There was insufficient operating time for the number of orthopaedic cases and hip fractures. Some other fractures such as children's fractures were treated outside the trust protocol of 10 days.

Patients and their families had access to translation services and to food to meet their cultural and religious needs.

There was evidence of learning from incidents and complaints at staff meetings although incidents were not always investigated promptly, which meant opportunities for learning and improvement could be delayed.

Service planning and delivery to meet the needs of local people

- Operational standards say 90% of admitted patients should start consultant-led treatment within 18 weeks of referral. The trust was now meeting these times in key areas after falling below the England average earlier in 2014. Staff had focused on improving rates in oral surgery (which were still greater than 18 weeks), trauma, orthopaedics and plastic surgery where waiting lists had been highest. Surgery services were provided in association with specialist services in other hospitals in the area.
- In the Hip Fracture Audit 2013 the trust performed worse than the England average in six of 10 measures. Only 3% of elderly patients with fractured neck of femur (hip fracture) were seen by an orthogeriatrician within 72 hours compared to 55% nationally, and patients waited longer for surgery than the timescale recommended in the NICE guidelines of 36/48 hours. The trust's performance here had declined from the previous year, and only met the recommended timescale in 30% of procedures. We did not see a strategy to improve this, although staff told us it was because there were too few trauma operating lists. However, the trust had achieved a high rate for the return home of patients within 30 days, and length of stay and mortality rates were within acceptable limits.
- The hospital was meeting the timescales for referral to treatment in seven specialties. Meeting the target was challenging and required running additional clinics. These were likely to be needed on an ongoing basis.
- The trust had made efforts to increase the timeliness of letters sent out when patients were discharged, and in October 2014 96.4% of letters were issued within five days. However, the majority of surgeons had opted to have their letters sent unverified to avoid delays. This meant that 43% were not verified and staff were not clear about arrangements to monitor the error level in unverified letters.

Access and flow

- The average length of stay on surgical wards (for short-stay patients) was 3.4 days. This was above the trust target of 2.2 days, but not out of line with similar hospitals. The length of stay figures had remained static since the previous year. Figures were slightly above the England average for elective orthopaedics and general surgery.
- There was scope to improve theatre use. Late starts and overruns were running at almost double the trust targets, and the number of hours lost to late starts by October 2014, the month before our inspection, had not improved over the past year. Theatre use in October 2014 was 75% for day patients, and 78% for elective surgery. Nationally the median is 90%, and the trust target was 82%. The proportion of overruns and late starts to surgery was about 13%. Lack of support services such as pharmacy and a reduced number of porters after 5pm was a limitation to extended use of theatre sessions.
- Self-completion forms for pre-assessment included a question on languages spoken and any interpreting requirements so this could be arranged in advance of appointments.
- The trust was meeting targets for the percentage of patients seen for endoscopy within five weeks by running extra sessions, but there was no budget for this additional activity that was required on an ongoing basis.
- Discharge planning was started at the pre-admission clinic or on admission, and involved numerous

professionals such as therapists and social services as well as family members. Pre-operative assessments identified concerns that needed to be resolved prior to admission for surgery.

- The trust was trying to reduce both the percentage of patients who did not attend surgical clinics (11%) and those who did not turn up for surgery, even though patients were texted or telephoned the day before they were due to come in. There had been some reduction over the past year, and the rate across specialities was about 10% to 11% in October 2013. The rate had been about 14% in the same month in the previous year. During the last four months of 2014 102 patients had not turned up for day surgery and a further 22 had cancelled on the day. This represented over 40% of operations cancelled on the day.
- There were not always enough beds on surgical wards. Every month about 100 surgical patients were cared for on medical wards for part of their hospital stay. However, we also saw medical patients on surgical wards that included the short-stay surgical ward. Surgical patients on medical wards were seen by a post-admission team that determined their management plan, and then by doctors from the medical assessment unit. Therapists confirmed there was a system to inform them about such patients**.**
- The hospital ran seven trauma lists a week on three mornings and two full days. Only two of these were delivered by consultants. Discussion at Mortality and Morbidity meetings in October had highlighted the need for more consultant-led sessions. Several staff told us that the number of sessions was insufficient to ensure all orthopaedic patients were treated promptly. This issue was not on the surgical risk register.
- Almost all elective patients attended a pre-assessment clinic held on weekdays between 8am and 5 pm. This clinic was well run as a one-stop unit that aimed to do all necessary tests on patients at the same appointment, and it saw 35 to 40 patients a day. Where possible patients were offered a pre-assessment on the same day as their outpatient appointment. Older patients with additional medical conditions were invited to anaesthetist-led sessions, held twice a week. We were told a third session was needed to meet demand. A survey in the previous year showed that most patients were pleased with their pre-assessment.
- We reviewed hospital cancellations of elective surgery on the day of surgery over the past few months, and the reasons. While some cancellations would always be unavoidable, those due to unavailable equipment, equipment that did not work or the absence of a surgeon (other than sickness) ought to have been identified further in advance. Although the proportion of cancelled elective procedures was not large, it was unsatisfactory for the individual patient to have surgery cancelled on the day. During our unannounced inspection we found that several planned orthopaedic procedures had been cancelled the previous week because beds were not available.

Meeting people's individual needs

- Patients were given a bedside information book that covered details such as what to expect during their stay, who's who and general information about the hospital. The trust internet gave good information about the hospital to the public and patients.
- The hospital advertised the availability of translation and interpreting services. Clinical and support staff were also able to help with interpretation.
- Dementia screening was carried out on all relevant patients. Food and fluid monitoring charts were used for all patients living with dementia, and staff also used the national Butterfly Scheme to alert them to people living with dementia. A butterfly in outline indicated that the person had a degree of confusion but had not been formally diagnosed. A small number of dementia friends supported and guided patients and staff. Carers of people with dementia were able to accompany patients to the anaesthetic room.
- Risk assessments were used to reflect individual needs such as failing memory or language difficulties.
- There were a range of food options to meet different cultural or religious needs, and inpatients received a booklet about food and drink. However, a number of 24-hour vending machines were found to be out of order at the weekend.
- Patients were treated in single sex areas throughout the wards and theatres.
- Multi-faith services and chaplaincy offered one-to-one support.
- A number of patients did not know the name of their consultant.
- Nurses and patients mentioned delays in dispensing take-home medicines. Some patients had to collect these after discharge.

Surgery

Learning from complaints and concerns

- There was a process for receipt, investigation and feedback on complaints. Information leaflets about the Patient Advice and Liaison Service (PALS) were prominently displayed, with information about how to make complaints. This was also covered in the patient bedside guide.
- There had been few formal complaints on the wards. We saw from staff meeting minutes that informal complaints and survey results were discussed. Staff also received positive feedback from patients.
- Complaints data for surgical areas was collected and reported as part of the clinical governance process. We noted that responses to complaints did not always explain how the hospital had learned from an incident, and how it would avoid a recurrence. Not all senior staff played a part in reviewing and resolving complaints

Are surgery services well-led?

Requires improvement

There was a lack of high level vision to draw the surgery division together. Different sub-specialities and even staff in the same speciality were working in isolation rather than as a surgical division with strong leadership.

Senior staff changes and interim management for more than two years in theatres had had a destabilising effect, and many processes and procedures such as training had been sporadic. Record keeping was patchy and minutes of meetings had not been kept.

It was too early to judge whether the two new appointments made in the preceding month would bring stability. One of the two appointments was a secondment for six months rather than a permanent post.

Elsewhere in the surgery division there was evidence of auditing and monitoring services. There had been recent changes to standardise trust-wide reporting procedures, and systematise learning and actions from meetings, including accountabilities for change and development. However, we observed that actions were not always followed through.

Although the service was meeting most targets for referral to treatment times by running additional services, there was no clear strategy for keeping on top of demand.

The three surgical wards were well-managed by senior sisters, and feedback about the nurse leadership and team working was positive. Nurses and junior doctors spoke of a culture in which problems could be escalated to senior management. Learning and development was encouraged and successes were celebrated.

Vision and strategy for this service

- We did not see a high level vision for surgical services beyond a generalised aim to meet the requirements of commissioners for compliance with the London Health Programmes London quality standards by 2017. Some individual sub-specialities worked as part of wider regional strategies linked to partner organisations and local commissioning groups. An example of this was the planned expansion of the endoscopy unit with another hospital trust. The prospective link with Chelsea and Westminster Hospital NHS Foundation Trust in 2015 appeared to have caused some planning blight.
- The surgery division was finding it challenging to meet the increasing workload and targets, and had not developed a strategic plan to keep on top of demand in the longer term. However, we noted plans in general surgery to change on-call rotas to enable patients to be reviewed within 12 hours and moves towards seven-day working. This plan did not extend to other surgical sub-specialities.
- At a day-to-day working level we observed staff in the day surgery unit in particular looking for ways to make improvements to the service offered. For example, staff were looking at the reasons why surgery was cancelled and highlighting to managers avoidable incidents such as 'no equipment'.

Governance, risk management and quality measurement

- The trust had restructured its governance arrangement from early November 2014. Theatres anaesthetics, critical care, pre-assessment, and decontamination were under one management line in the surgery division. Surgical wards, doctors and specialist teams were in another management line. Senior staff told us that the changes had not had an impact on the running of services.
- The department collected suitable information on the safety of the service and treatment outcomes, and there were arrangements for passing relevant information up to board level that included risks. Risk registers contained some long-standing risks such as

non-compliance with the EU safer sharps directive (required by law from May 2013). This indicated a lack of pace in responding to some risks. Other issues of concern mentioned by staff such as the lack of resident registrar at night or delays in surgery for some patients were not recorded on the risk register.

- Consultants received no encouragement to participate in the management of the surgery division and there was some reluctance to use standard management reporting systems. For example, incidents such as postponed surgery or absence of sufficient operating time were not being escalated through the incident reporting system.
- The trust had recently asked staff to record complaints on Datix (patient safety incidents software), and used this data to display the numbers of complaints on the ward.

Leadership of service

- There had been a long period of instability in the management of theatres. During this time some processes and procedures such as training updates, hand washing audits and consistent record keeping enabling analysis and planning of performance had been neglected. There was now a mismatch between the current staffing establishment and the number of procedures being undertaken. The spend on bank and agency staff had risen. It was too early to judge whether new appointments were strong enough to put the theatre management quickly on a firm footing.
- Consultants were not well engaged in the management of the hospital.
- The surgical wards were well led by nursing sisters, and had strong communication between nursing staff and therapists. The surgical matron attended monthly ward meetings. Senior nurses were seen to lead by example and were proud of their wards and their specialism.

Culture within the service

- Nursing staff said they were well supported by line managers in their work and in their training and development, and considered the work environment friendly. We saw examples of good teamwork among nurses.
- Junior doctors considered the hospital friendly and supportive, and felt they had excellent learning opportunities at the trust. There was a well-attended weekly grand ward round. There were two Deanery registrars, which demonstrated external confidence in training. From the 2013 NHS staff survey staff in the surgery division scored slightly better than other areas in overall engagement.
- The trust had no whistleblowing cases open at the time of our inspection. Staff we spoke to were aware of the trust's whistleblowing policy.

Public and staff engagement

- The division obtained feedback from patients through the FFT and the results were displayed on each ward, although not always in areas where visitors would see the information. The bedside guide encouraged patients to complete this, and also drew attention to the discharge questionnaire of the National Inpatient Survey. There were boxes for comments cards on wards, but it was not clear what cards should be used for comments. However, we did not see evidence of staff seeking systematic feedback on patient experience except in endoscopy and pre-assessment.
- Staff said that the Staff Excellence and Achievement Awards were motivating, particularly those for team work. Nursing staff were seen to be proud to work in the hospital.

Innovation, improvement and sustainability

- A virtual fracture clinic had been set up to review fractures identified in the urgent care centre (UCC) as well as through A&E. This potentially allowed doctors to identify priority cases and avoid unnecessary patient attendances at clinic.
- The hospital had been shortlisted for awards by the Health Service Journal in IT in 2013. Junior doctors praised the IT systems at the hospital, which they said were very intuitive to use and enabled them to obtain patient histories very quickly.
- The service's approach to change was driven more by external pressures than proactive action. Modelling was carried out to assess the impact of changes, particularly the impact on targets for the throughput of elective surgery and the 21/62-day cancer target, which the trust had laid on additional services to meet. It was clear that seven-day working, which included multidisciplinary patient review within 14 hours of admission, could only be achieved with additional resource and would have significant cost implications.

Critical care

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

Information about the service

The critical care unit (CCU) at West Middlesex University Hospital NHS Trust provides care for patients with a diverse range of medical and surgical problems, with the exception of neurosurgical, paediatrics and cardiothoracic specialities.

The Intensive Therapy Unit (ITU) has capacity for 9 intensive care (level 3) patients but is funded for 5 and has 4 spaces for High Dependency Unit (HDU) patients. The unit is flexed up and down depending on level of critical care required. The ITU and HDU are divided into two areas, next door to one another. The ITU has two side rooms, one of which is a negative pressure room. The HDU also has one side room. Each of the bed bays are screened off by curtains.

The critical care team provide an outreach service to support patients being nursed on acute wards, whose condition is at risk of deteriorating or who have moved down from higher levels of care (level one).

We spoke with a full range of staff that included: consultants; doctors; trainee doctors; and nurses from different grades. We met the unit nurse manager and critical care lead consultant. We also spoke with: physiotherapists; an outreach nurse; the engineer overseeing ICU equipment; and the unit's domestic staff.

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

Summary of findings

We judged the critical care services at West Middlesex University Hospital to be good overall.

Patients and relatives spoke highly of the care and treatment they received in ITU and HDU. They described staff as "fantastic" and the facilities as "world-class". Patients said they were treated with respect, and their dignity and privacy was maintained. Relatives told us staff were always welcoming, kind and handled difficult conversations sensitively.

Guidance from the Intensive Care Society (ICS) advocates that all level two and three patients should be cared for in a closed unit (i.e. one area), and that medical oversight of the unit should be provided by intensive care physicians. This approach has been shown to improve mortality and morbidity. The CCU operates this model of care. Multidisciplinary (MDT) team working ensured patients received a holistic approach to care and treatment. Critical care consultants worked in the unit for a week at a time, and the consistent care has reduced patient stays.

Care and treatment was delivered by trained and experienced nursing staff who worked in dedicated teams. There was a clear reporting structure and staff told us they felt supported and confident in their role. Temporary staff, newly-qualified nursing and medical staff said the core staff were supportive and friendly.

The unit participated in recommended national audits and local audits to measure the outcome and quality of

Critical care

care patients' received. There was a clear incident reporting system and staff felt able to report incidents and raise any concerns. Staff were able to describe incidents and the learning from them. Thank you cards and letters were displayed as you entered the unit giving patients and staff a positive view on arrival.

Cleaning audits, incidents, concerns and complaints, and the response to them, were displayed on the walls in the staff rest room to inform staff of any changes that had been made.

The unit was clean and well maintained. However, it was cluttered in places because there was limited storage space due to changes in the hospital's bed configuration.

Are critical care services safe?

Good

We have judged the services delivered at West Middlesex University Hospital CCU to be safe.

Care and treatment was delivered by trained and experienced nursing staff who worked in dedicated teams. A dedicated consultant remained on the unit between 8am to 7pm who was then on-call overnight only for CCU. The consultants worked on a week–by-week rota to promote consistency in care and treatment.

The unit practiced the closed unit model of care recommended by the ICS. Patients benefitted from a holistic approach to safe, quality care, treatment and support. We saw people's needs were assessed, planned and delivered in a way that maintained their dignity and promoted their rights.

The service demonstrated effective systems and a transparent culture to reporting, investigating and learning from incidents. Morbidity and mortality reviews were held routinely. Staff received competency-based training, and were regularly supported through one-to-one bedside teaching practice.

Records were completed in most cases. However, we found gaps in some checks such as medication fridges, emergency equipment and the negative pressure room readings. These were periodically audited and any concerns were raised with the individuals or reported on Datix (patient safety incidents software) if necessary.

There was an ample supply of equipment and medical supplies to meet peoples' needs. In most cases equipment was cleaned in line with the trust infection control policy. However, we found a few areas where cleaning was not of the highest standard. For example, we found staining of the underside of commodes, blood droplets on the blood gas machine and the metal bins caused by rusting in the corners.

Storage was a concern for the unit because the hospital's recent bed reconfiguration resulted in CCU losing a storage area. Surplus equipment now had to be stored on the unit and in rooms intended for meetings.

Critical care

Incidents

- There were no Never Events (serious largely preventable patient safety incidents that should not occur if proper preventative measures are taken) reported in the CCU.
- ITU/HDU reported eight serious incidents between May 2013 and July 2014. Five involved pressure ulcers graded three and above. Two others concerned unexpected deaths, and one related to Clostridium difficile (C. difficile) and healthcare-acquired infections (HCAI).
- All incidents were thoroughly investigated and a root cause analysis was completed to identify the cause of the incident and lessons learnt. Staff we spoke with were aware of the incidents and the learning and actions from them.
- One incident concerned a patient who had died because they had become disconnected from their ventilator while left unattended for 30 minutes in an HDU side room. The incident was thoroughly investigated by the quality and risk (Q&R) committee, which drew up an action plan and lessons learned and reported them to CCU staff and to hospital wards.
- One of the actions from the incident stated that level three patients must not be left unattended. However, when we visited CCU we saw one patient in a side room, ventilated by a tracheostomy and left unattended while the member of staff prepared a bed bay in the main unit for an urgent A&E admission. The member of staff assured us they were keeping a close eye on the patient from the bay. However, even with the side room doors open it was difficult to observe the patient continually without regularly going into the room. Monitoring used on the unit now allows remote monitoring of patients.
- As a result of the incident the unit had also installed an audible alarm at the nurses' station so that any member of staff would become aware of a problem and be able to respond quickly.
- Staff were encouraged and supported to report any incidents as they occurred using the Datix hospital reporting system. Staff we spoke with described how they would report incidents on Datix and said they felt confident to raise their concerns with a senior member of staff.
- Incidents and complaints were discussed at the unit's monthly meeting. The nurse in charge was responsible for reviewing Datix on a regular basis.
- We reviewed the 175 CCU incident reported between May and November 2014. Reportable incidents included, among others: medications errors; slips and falls; staffing levels; abuse; patients' case notes/records; and lack of equipment and facilities.
- If a theme was identified the incidents were investigated and discussed with the individuals concerned, and all staff were reminded of the correct procedures and protocols. We were given an example of a clinician drawing up sedation drugs in case they were required for a patient. This meant if the drugs were left out for long periods of time they could become unstable, or could be wasted if not used. After an investigation is was found that the doctor had learnt this practice at another hospital and was unaware of the protocol at West Middlesex University Hospital. All staff were reminded of the protocol.
- We were told of an increase in ITU incidents that involved pressure ulcers after the trust changed mattresses in the hospital. The unit introduced a different style of pressure redistribution mattress and daily patient checks by the responsible nurse, and the nurse in charge recorded any changes on the daily patient observation chart to reduce the problem. Audits in the change in practice showed a decrease in incidents.
- The directorate level risk register identified patient safety issues because the mortality monitoring system was not sufficiently robust or effective. As a result the CCU implemented enhanced clinical practices to improve patient care and reduce mortality.
- There was a decision to ensure that all divisional meetings address mortality issues and record and disseminate actions effectively. Staff used a standardised template to report deaths/morbidities.
- ITU deaths had recently started being reported in this way. However, staff told us the standardised trust tool was not appropriate because some questions were not relevant to critical care patients.
- Monthly divisional morbidity and mortality (M&M) meetings took place, and the report was fed into the Q&R committee and the trust's mortality review group.

Safety thermometer

- A Safety Thermometer (an improvement tool for measuring, monitoring and analysing patient harm and 'harm-free' care) was produced for the CCU. However, it was not displayed on the unit as it was on other wards

in the hospital. This meant patients and visitors to CCU were unable to see whether any harm to patients had been identified, such as falls or pressure ulcers. We were told that boards to display the Safety Thermometer information had been requested to bring them in line with the rest of the hospital.
- Quality reports, audit results and a summary of incidents at CCU together with the changes made were displayed in the staff room. However, visitors to the unit were unable to see this information.
- A band 7 nurse was responsible for collating the unit's data on pressure sores acquired in the CCU. The information was displayed in the staff room and discussed at the band 7 away day meetings. Any concerns and trends were discussed, and action to reduce the number of cases was disseminated to staff by team managers.

Cleanliness, infection control and hygiene

- The unit provided audits for the infection prevention and control (IPC) monthly divisional report. These included audits on: HCAIs; hand hygiene; MRSA screening; C. difficile; blood culture collection; isolation of patients with diarrhoea; training in IPC; any issues in IPC; and environmental cleaning. No compliance was seen as a 'fail' and reported in the divisional report. We saw that any issues and learning were identified in the report.
- There were low rates of infection on the unit. There had been one case of MRSA and no cases of C. difficile or central venous catheter (CVC) infection in the last six months. CVC catheter proformas were used and daily checks completed.
- Patients with infections were risk assessed on how the spread of infection was controlled and could be isolated in a side ward. However, this was not always necessary because of the CCU's infection and control measures.
- We observed staff following hand hygiene protocol. Signage was used to remind staff and visitors about hygiene measures when providing care or visiting patients with infections. However, we noted that one patient in a side room did not need isolating, but the notice outside the door indicated the patient was in isolation due to an infection. Staff acknowledged they could become immune to signage if it was always in place and could miss certain control measures if unaware of the patient's status. This sign was removed prior to the end of our inspection.
- We observed nursing staff challenge doctors on the importance of wearing personal protective equipment (PPE) before examining patients put in isolated because of an infection.
- All patients were tested for MRSA on admission to CCU and once a week thereafter.
- The January 2014 Care Quality Commission (CQC) inspection had identified a need for more robust auditing of cleaning. As a result senior ward staff were trained in the national standards of cleanliness with ISS (contract cleaners) staff so they knew the standards to aim for, and how cleaning targets were audited.
- A weekly cleaning audit took place with the cleaning contract company and a senior nursing representative. The results were displayed on the ward each month. Results in October 2014 showed the unit had achieved 95.38% compliance with the standards, which was slightly higher than the ward's target of 95%.
- IPC results were reported at a monthly divisional meeting.
- Furniture/units were moveable in order to clean underneath and behind them. We found these areas were clean and dust free.
- The majority of the unit and equipment used was clean and free from dust. Empty bed spaces were clean and the date when cleaned displayed on most of the equipment in the area. However, we found in some areas ring marks from containers on the metal surfaces and caps to containers underneath some of the monitoring equipment. There was a light coat of dust on the less accessible areas around monitoring equipment.
- We found blood droplets and spillages on the blood gas machine and on the floor in the room that housed the equipment. This was cleaned when we brought it to a member of staff's attention. However, when we looked at the room the following day there was fresh blood spillage that had not been cleared up by the person using the machine.
- Most of the sharps bins were no more than three-quarters full, and all the bins we looked at were dated and signed by a member of staff in line with policy.
- A majority of the clinical waste bins were plastic and easy to clean. However, there were a few metal bins in the area that were rusting at the edges and marked.
- Some areas such as the sluice room and blood gas room were not easily accessible to staff for cleaning

because equipment were in the way, for example, commodes and IV stands . This was because of limited storage space on CCU and no areas available to store excess furniture or equipment.
- The door to the sluice/dirty room was propped open by a commode. Cleaning products were left on the side in the room and easily accessible to anyone.
- The tops of the hand wash bottles in the sluice and anterooms outside of the side rooms were clogged with congealed soap.
- The commodes in HDU and ITU were both reported to be clean on a sticker. There was no date or responsible person named on the sticker. We found both commodes to be stained and dirty under the seat.
- At our unannounced visit on 13 December 2014 we found the door to the blood gas room propped open with a clinical waste bin. The bin lid was in the open position and some wipes had not been thrown into the bin properly and were left on the edge of the bin.
- We also found the clinical waste cupboard in the corridor leading to the CCU open and unlocked. This was accessible to anyone. The clinical waste bins were not locked and there were bags on the floor. We spoke to a member of staff and they locked it immediately while telling us it was often left open and unlocked.

Environment and equipment

- The unit had an ample supply of the equipment required to meet patients' care needs. We saw records that demonstrated that equipment was regularly maintained and serviced. Staff were trained in the use of equipment.
- Resuscitation equipment was available on ITU and HDU. However, we found the oxygen was out of date on both trolleys. We advised staff and the oxygen in ITU was replaced immediately. The one in HDU was still waiting to be replaced at the time we completed our inspection.
- The resuscitation trolleys were sealed. This seal was checked by a member of staff once a day. Every week the seal was broken and the trolley's contents were completely checked. However, we found there were gaps where the checks had not been completed. The resuscitation team audited trolley checks every six months, and any concerns or errors were reported as an incident on Datix.
- Emergency/difficult intubation equipment was available, and staff were aware of its location in the event of an emergency. Emergency tracheostomy equipment was readily available next to the patient's bedside. Best practice requires a sign to be placed over the patient's bed with details of the tracheostomy including the size and type used. We did not see this for all CCU tracheostomy patients, or on the hospital wards.
- We saw an intubation kit for children in the unit. Staff were unaware of where this had come from and did not know why they had it because they had not been trained to intubate children. On examination the kit was found to have adult blades and unsuitable for children. This kit was removed after we spoke to the ward manager.
- The unit had a negative pressure room (an isolation room to prevent cross-contamination between rooms). This room was not in use.
- Single use per patient equipment was used such as slide sheets and blood pressure (BP) cuffs.
- We identified that equipment storage was a concern on CCU. Some equipment was screened off in one of the HDU bed bays, there was equipment stored around the nursing station and in the meeting room. Some of the smaller storage rooms and sluice were cluttered with trolleys or supplies. We discussed this with the nursing and medical team who agreed that it was an ongoing issue as they had lost a storage room to another ward.
- Equipment and beds were cleaned and covered with plastic sheeting when not in use. Not all the equipment was marked with a sticker stating when it was last cleaned and the member of staff responsible. However, we were assured that equipment without a sticker or date would be re-cleaned prior to use and would ordinarily be placed in a store room if there were space.
- During our unannounced inspection on 13 December 2013 we noticed resuscitation team and CCU medical supplies stored in unlocked cupboards in a corridor outside the CCU doors. Many of the supplies were out-of-date, some as old as 2012. The equipment had not been serviced or calibrated for a number of years, and there were also two bags of intravenous (IV) fluids. We discussed it with a member of staff who told us the supplies and equipment had been stored there due to lack of space on the unit. They agreed that much of it should be destroyed. We spoke with the unit manager the next available working day and they told us they had asked the hospital stores to ensure its removal.
- Bins did not have a soft close mechanism and were noisy when opened and closed. This could disturb patients trying to sleep.

- It was disorientating on the ward because there was no daylight, and clocks did not display the day of the week or date. Best practice advises that wards should have clocks displaying the time, day and dates to help conscious patients.

Medicines

- Staff had the relevant competencies to carry out IV drug administration.
- Agency/temporary staff competency was checked and signed off by the senior nurse in charge. Agency staff told us they were not able to give IV drugs and it was the responsibility of permanent staff.
- Medication administration records (MAR) we reviewed adhered to the national prescribing guidelines and were recorded appropriately.
- There was a potential to bolus (the administration of a discrete amount of medication/drug to raise its concentration in blood to an effective level) a drug through the infusion pumps. The name of the drug was displayed on the pump screen when selected, but the bolus facilities could be used no matter which drug was entered. This meant that without careful reading a bolus of an incorrect drug could be given inadvertently. Consideration should be given to clearer labelling or colour coding.
- The pharmacist visited the ward every day and reported a good working relationship with the critical care team. There was an on-call pharmacist outside working hours.
- 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 securely stored.
- Medicines stored on the unit were securely stored.
- The temperature check of the medical refrigerator was not always done consistently. Although there were no records that the temperature was outside of the safe range when checked, there were gaps in the checks. For example, from 1 to the 27 November 2014 checks had not taken place on 16 occasions.

Records

- Records were securely stored in a way that promoted confidentiality.
- Bedside notes and charts were up-to-date, clear and organised in chronological order. Vital signs were well documented, along with cardiac and respiratory indicators. Neuropathic indicators, such as pain and pupil reaction, were well documented.
- CVC lines forms were filed and daily checks documented.
- The consultants used a daily review template. However, we found that that they were not all completed and a number of versions were available. We were told by some that one version was a pilot, but there were conflicting views on its use from different members of staff. One consultant suggested the pilot template had been implemented.
- We noted that information about personal care was not always completed even when it had been done. For example, patients were supposed to receive a weekly hair wash. However, it was not indicated on the chart or in the nursing notes that this was done every week.
- If it was possible patients were weighed on a weekly basis. We noted that we were unable to find out if a patient's weight had remained the same each week, or whether it had not been possible to weigh the patient and therefore if their weight had been carried over to the next week.
- Patients' delirium checks were not completed in nursing or medical notes.

Safeguarding

- The staff we talked with demonstrated a good understanding of what safeguarding vulnerable adults and children meant in practice and were able to describe how to escalate any safeguarding concern. They were aware how to contact the trust's safeguarding link nurse.
- We observed medical staff having detailed discussions about patients' next of kin and who had legitimate access the patients' information at handover meetings.

Mandatory training

- We were shown the staff training matrix that indicated the mandatory training staff were required to undertake. These records showed that the unit had not reached compliance with the trust's targets for staff to complete mandatory training in 15 of the 28 required subjects.

Assessing and responding to patient risk

- The nurse in charge assessed each patient with the nurse responsible for the patient during each shift for particular risks such as pressure area care.
- Early warning scores (EWS) were completed on patients prior to discharge to the ward, and we observed that one patient's discharge was delayed because of an unsatisfactory EWS.

- Patients were monitored for different risk indicators. Each ventilated patient was monitored using capnography, which monitors 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, transfers and tracheostomy insertions.
- There were delirium assessments in the template for nursing records. However, we did not find that they had been completed in the five sets of notes we reviewed. (Delirium is an acute, fluctuating change in mental status, with inattention, disorganised thinking, and altered levels of consciousness. It is a potentially life-threatening disorder characterised by high morbidity and mortality. Delirium is common in the intensive care unit especially among mechanically ventilated patients. In critically ill patients it is associated with an increased length of stay and increased mortality.)
- Staff identified areas on patients' bodies that were more susceptible to getting pressure ulcers such as where nasogastric tubes touch the face and ears. As soon as any redness in the skin is identified staff protected the areas to ensure they did not become ulcerated.

Nursing staffing

- All ventilated patients (level three) had a minimum of 1:1 nursing support, and level two patients had 1:2 care. This was in accordance with the guidance of the Faculty of Intensive Care Medicine Core Standards for Intensive Care Units.
- From our observations, the rotas we viewed and the conversations we had with staff on CCU we found appropriate staff numbers and skill mix.
- The unit was overseen by a ward manager. A matron had been recruited and was due to start in January 2015. The unit had: six band 7 nurses; 17 band 6 nurses (one on long-term leave); 23 band 5 nurses (one on long-term leave); two band 5 healthcare assistants (HCA); and one band 3 HCA. There was another nurse responsible for auditing in CCU. Five of the team supported the outreach service, and a senior nurse was responsible for overseeing the outreach team and training/personal development of the nursing staff. Four other critical care nurses were in training to provide outreach services.
- A band 7 senior nurse was allocated to every shift to ensure senior cover 24 hours–a-day.
- Each band 7 nurse had their own team of eight nursing staff. Staff spoke positively about working with a regular team.
- The unit had an extra member of staff who floated in the department to support nursing staff and to provide outreach services in the hospital. However, this post regularly filled in nursing gaps caused by sickness or other absence. We talked to a number of staff in the hospital about the outreach service. They spoke positively about the service and were not aware of staff shortages that would prevent the outreach service being able to respond in a timely manner.
- Permanent staff absence was covered by bank (staff who work overtime in the trust) or agency staff. Senior staff told us they always tried to use bank or agency staff known to them.
- Staff indicated that a number of the hospital's regular staff choose to work through an agency as opposed to the hospital bank because the rate of pay was higher. All agency staff were qualified intensive care nurses.
- Temporary staff were inducted into the unit, and permanent staff were able to show us the checklist they worked to they did this. Staff told us unsuitable temporary staff were reported to the agency they worked for. The agency staff we spoke with told us the staff on the unit were very supportive, helpful and guided them well.
- The unit has a structured nursing handover at the start of each new shift. The senior nurse on duty informed the incoming team about the patients' history and any changes to their care and treatment. The nursing staff chose the patient that they would like to support, and had a thorough handover from the nurse who had been responsible for their care in the previous shift. The senior nursing staff had a further handover discussing each patient in detail and any unit concerns or issues. We saw that this was a long process and meant that the senior member of staff finished their shift up to an hour later than rostered.
- A board at the entrance of the unit identified the nursing staff in charge of the unit.

Medical staffing

- The consultant to patient ratio across ITU was 1:9 if all the beds in the unit were occupied. This was in line with the Core Standards for Intensive Care Units guidelines that state the ratios should not exceed 1:8 -1:15.

Critical care

- Consultants reviewed patients twice daily and handed over to the hospital at night team every day for out-of-hours cover.
- We observed a morning handover meeting from the hospital at night team to the unit's team. We found it was clear, organised and well structured. The senior lead for the day allocated jobs and everyone understood their roles and responsibilities for the shift.
- A dedicated consultant remained on the unit between 8am to 7pm and was accessible to the nursing staff and patients throughout this time. They were clear from other clinical commitments during their shift on the unit.
- Patients were reviewed by a consultant in intensive care medicine within 12 hours of admission to the unit.
- All potential patients to the unit were discussed with the intensive care consultant prior to admission.
- There was immediate access to a practitioner with advanced airway techniques in and out-of-hours.
- A board at the entrance of the unit identified the consultant in charge of the unit.

Major incident awareness and training

- Staff had received general fire training, but had not received fire training specific to the ITU and HDU areas. A practice drill had not been performed and staff were unaware of how an evacuation would work in reality.
- West Middlesex University Hospital was the designated second hospital in the area to take in casualties from any major incidents from terminals four and five at Heathrow Airport. Major incident communication exercises took place periodically.
- The unit planned for more staff to take annual leave over the summer months when there were historically fewer patients. This meant there were fewer numbers of staff taking leave over the winter period when the pressure on beds increased.

Are critical care services effective?

Good

From the data reviewed, our observations and conservations with staff, we judged the service delivered in ITU and HDU was effective.

Care delivered was measured routinely to ensure quality and improve patient outcomes. The unit's mortality rate is currently 0.85%, which was compared favourably to units of a similar size The department was able to demonstrate that it was meeting or exceeding national quality indicators on a continuous basis.

We found the care delivered in the department was evidence-based and adhered to national and best practice guidance. Staff had easy access to local policies and procedures. However, we found a number of these were outdated or had no review date. A working party had recently been set up to review this.

Patients had their pain, nutritional and hydration care continuously assessed and met.

All new and temporary staff were provided with an induction and orientation pack. Newly-qualified staff were allocated a mentor and underwent competency-based assessments to ensure they had the skills and confidence to do their jobs. CCU staff and in the hospital that provided support to high dependency patients received one-to-one bedside training from the outreach team.

There was strong evidence of a MDT and multi-professional working in critical care.

Evidence-based care and treatment

- Staff had access to a library of policies and procedures specific to the unit. They were accessible and easy to locate. Hard copies were also available should the IT system fail. However, we found that there were a large number that were out-of-date. For example, we found that the policy for vasopressin was two years out-of-date. A number of the policies did not have a review date such as the policy relating to insulin, which meant we were unable to establish how up-to-date they were.
- The unit had a lead consultant responsible for clinical guidelines and ensured the unit adhered to national policies and guidance such as guidance from the National Institute for Health Care and Excellence (NICE) and the National Confidential Enquiry into Patient Outcome and Death (NCEPOD).
- The CCU's clinical guidance group was responsible for reviewing critical care's guidance and policies. We were told that a system was being developed to flag up those that required reviewing or updating.

Pain relief

- The CCU used a standardised pain scoring tool.

- Patients reported being regularly asked about their pain levels and offered appropriate medication if required.
- If treatment was no longer benefiting a patient a decision was made in conjunction with family members/advocates to withhold life-sustaining therapies, care and medication. A move was then made towards providing comfort and palliation to reduce any distressing symptoms in the last stages of the patient's life.

Nutrition and hydration

- ITU and HDU patients' nutrition and hydration requirements were assessed and reviewed by the dietician who attended the unit every weekday. Each patient received a plan of dietary requirements.
- There was an out-of-hours nutrition regime for patients admitted over the weekend.
- Staff told us there was some concern at times when patients could go without food for too long because of cancelled operations. In cases like this the dietician could increase the speed food is administered so that they catch up on calories and nutrition.
- Total parenteral (the route by which nutrition is administered other than through the digestive tract, for example by injection) nutrition can be ordered and prepared in a sterile pharmacy area
- The Malnutrition Universal Screening Tool (MUST) was seen to be completed and recorded in patient records. Patients on special diets could order from the kitchen. The menus contained the calorie content of each meal and drink.

Patient outcomes

- The unit participated in a national database for adult critical care as recommended by the Core Standards for Intensive Care Units (the Core Standards). They contributed data to the Intensive Care National Audit and Research Centre (ICNARC) database for England, Wales and Northern Ireland.
- Results from ICNARC showed that patient outcomes and mortality were within the expected ranges when compared with other similar services.
- The unit had participated in the North West London Critical Care Network Quality Measures for the last seven years. They were consistently the equivalent or better than comparative sites.
- In the assessment period from July to September 2014 they achieved 100% in all areas measured apart from shortfalls in: VAP bundle (ventilator-associated pneumonia, - a reduction care bundle is a grouping of evidence-based, high-impact interventions), which scored 97%; and ICU capacity that scored 67%. There had been no unplanned readmission rates to the unit during this period.
- We were shown evidence that consultant cover for a week at a time had resulted in a shorter stay for patients.
- The potential donor audit showed on average one potential donor was missed every two months. As a result of this all patients considered to be reaching the end of their life were discussed with the specialist nurse for organ donation, who would follow up with family/ advocates of patients.

Competent staff

- Records showed that seven out of 47 staff had not received their annual appraisal. Those that had not had one were either on a long-term absence from the unit, or had only returned to work in 2014. All the staff we spoke with had received an annual appraisal, and were positive about the experience and described the value of an annual review to discuss their achievements and goals.
- New doctors received a trust, department and equipment induction. They shadowed an experienced doctor for a minimum of two weeks before being able to work independently. Their working practices were closely observed by senior staff and peers. The anaesthetics team discussed new doctors' development and raised any objections or concerns before a decision was made to place them on the on-call rota. New doctors spoke positively of the experience and told us the lines of support were very clear.
- All nurses new to the unit received an orientation pack that introduced staff to: key personnel; general administration and procedures; professional development and competencies; nursing documentation; and IT systems. An orientation checklist was completed and signed off by a senior member of staff or training lead.
- Newly qualified band 5 nurses were supernumerary on the unit for a minimum of four weeks. It was the responsibility of the nursing teams to provide preceptorship (practical experience and training) and mentorship for new nurses. They worked alongside a

mentor until they had achieved key competencies to work independently with support close by. They were supported in regular one-to-one practice development by the outreach lead nurse.
- The unit offered post-registration courses that are affiliated to Buckinghamshire New University and the University of West London. Course and study days were also regularly available in developing competencies, leadership and management.
- The outreach team supported one-to-one learning and development for nursing staff supporting patients with high dependency needs across the hospital, which took place 8am to 8pm. Outside of these hours it was the responsibility of the hospital at-night team. There was some concern that the sister might be too busy during the night to undertake one-to-one teaching.
- All temporary staff received a one-to-one orientation of the unit, equipment and procedures. A check list was used to ensure all competencies were covered. The agency staff we spoke with talked highly of the support they received as a temporary member of staff. IV drug administration competencies were signed off by the senior nurse in charge before a temporary member of staff was able to do this independently.
- Regular bank, agency and locum staff were used whenever possible. Regular temporary staff might not have worked on the unit for a while, and although they received an initial induction to the unit, we were unable to find out whether these staff would have received any updates on procedures, policies or working practices since their CCU last shift.
- All medical staff were required to complete their continuing professional development (CPD) to maintain their registration to practise.

Multidisciplinary working
- Each morning ITU and HDU held a morning ward round led by the ITU consultant along with the registrar anaesthetist. All members of the MDT involved in a patient's care attended this round along with the nurse in charge of the unit.
- A weekly MDT meeting took place to review all patients under the care of the CCU, case studies, audits and research on the unit. These meetings included: consultants; nursing staff; outreach team; dieticians; physiotherapy; and pharmacy.
- Discharged patients were followed up by the critical care outreach team.
- The outreach team supported patients' and staff nursing patients who required a higher level of care on the main hospital wards from 8am to 8pm, seven days-a-week. Although generally avoided, the outreach team could be pulled to work in the CCU if there were staff shortages there.
- Care for patients with tracheostomies was supported by the outreach team. There was a weekly ward round between the outreach lead and ENT nurse specialist. Staff reported that this was a very proactive working relationship that supported patient care.
- The outreach team handed over to the hospital at night team at the end of their shift and this was repeated the following morning by the night team back to outreach.

Seven-day services
- The unit had six ITU consultants, who worked a weekly rota from 8am to 7pm seven days-a-week. Staff reported positively about this arrangement. Nursing staff said they knew how each consultant liked to work. Also the consistency was good for the team and patients' treatment and care.
- The unit had 24-hour consultant cover on an on-call basis out-of-hours and at weekends.
- The hospital at night team were made aware of critical and high dependency patients across the hospital during the handover meeting that took place every night at 10pm.
- The senior management reported that medical locum or agency cover was always provided by medical staff known to the unit.
- The critical care outreach service operated seven days-a-week from 8am to 8pm.
- A pharmacist provided information and guidance and checked each patient's medication chart daily.
- Patients were assessed by the physiotherapy team every day during the week Monday to Friday, but not at weekends. A physiotherapist had been recently recruited to work solely in CCU to provide specialised support.
- The consultant microbiologist visited the unit daily.
- There was access to CT scanning 24 hours-a-day.

Access to information
- The medical staff on the unit told us they kept in regular contact with admitting doctors about their patient's

progress. We saw referring teams visiting their patients, and the critical care consultant discussing the patients' care plan. Staff told us they also had informal catch up chats when they saw their colleague in passing.

- A discharge summary template was used when a patient was being discharged to a main hospital ward. A nursing and doctor discharge summary was provided to staff on the ward. The discharge sheet was a different colour so it was easily identifiable to staff on the admitting ward.
- We were told there was also a verbal handover when patients were discharged from critical care. However, we did not see any evidence that these conversations had documented. We also found that the content on the discharge summaries was not checked by a senior member of staff.

Consent and Mental Capacity Act and Deprivation of Liberty Safeguards

- Care and treatment was given to patients who could not give informed consent. General day-to-day care and treatment decisions, such as giving medications, personal care and performing tests were made by the medical and nursing teams.
- If decisions on more fundamental issues were required, staff told us they hold best interest discussions in line with the provisions of the Mental Capacity Act 2005. They said the meeting took place with advocates for the patient to hear all the views and opinions on the treatment options.
- 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 that if and when the patient regained consciousness, or when the emergency situation had been controlled, the patient was told what decisions had been made, by whom and why.
- Although the consultant explained that they assessed a patients' mental capacity verbally we did not see anything documented in the notes. For example, documentation for a patient admitted from A&E to ICU indicated the patient was orientated. When they arrived in ITU the patient said they wanted to go home. There was no written evidence that the patient's mental state was assessed. However, the patient did not refuse treatment and lines were inserted without any difficulty.
- We did not see evidence of patients' mental capacity being assessed as their condition changed.

Are critical care services caring?

Good

We found the critical care service at West Middlesex University Hospital was caring. Patients we spoke with told us they were always treated with dignity and respect and their care needs were met by kind and professional staff. A patient's relative described the service as "world class" and the staff as "fantastic".

Patients and their relatives told us they were involved in the care planning process and felt well informed. They described the doctors and nurses as "patient" and "informative". We were told they always explained things in a way the patient and their relatives understood and allowed time for questions and time to think about what they had been told. Relatives told us that difficult conversations were handled well and in a sensitive manner.

Staff described ways they supported patients on an individual basis. A member of staff said: "We respect peoples have different' backgrounds and therefore treat each patient as an individual. We focus on their needs and support their friends and relatives however we can."

Compassionate care

- The patients and relatives we met spoke highly of the care they received in ITU and HDU. Patients and relatives said "the staff are really good" and "the nurses couldn't do anything more for you, they really look after you".
- We observed patients being treated in a kind, caring and respectful way that promoted their dignity. We heard nurses talking quietly and reassuringly with patients while caring, taking observations, performing and moving the patient, even if they were unconscious.
- The unit was sensitive to patients' and relatives' needs. There were set visiting hours to allow patients to rest and staff to undertake ward rounds, observations and give personal care. However, staff told us they would accommodate patients' visitors as much as possible at all times. One relative told us they travelled a long way to visit their family member and staff allowed them to stay as long as they wished. If a patient was coming to

the end of their life visitors could stay as long as they wished. Visitors told us the staff would always ask them politely to wait outside when they had to support the patient in their care.

- We observed staff maintaining a dying patient's dignity and privacy by closing the curtains around their bed bay, and bed bays either side. There was a large number of the patient's family present and this made the unit very busy during the evening and night. Staff explained what was causing the increased activity and reassured visiting relatives/friends and patients who were awake.
- Physiotherapy staff told us how they encouraged patients' friends and family in supporting their family member, such as holding their hands, rubbing moisturising lotions into their skin or performing some movement of their limbs.

Patient understanding and involvement

- There was positive feedback from the patient survey with high scores for communication and understanding of diagnosis.
- Patients who were able to speak with us told us they were involved with their care and the decisions taken. One patient said: "The staff have explained everything to me; most of the doctors explain things in a way I understand. I can ask questions if I don't understand anything." We heard staff give good explanations of what was happening and included relatives when possible.
- Relatives of patients who were unable to talk with us told us they were kept informed about their family member's condition, tests and treatment provided. Friends of patients told us they were kept informed but only received the information they were entitled to.
- Staff told us relatives could ask to speak with a doctor at any time. One relative told us they asked to speak with a doctor because they could not remember everything they had been told when their family member was admitted to the unit. They told us the doctor was patient and methodical in explaining everything to them again.
- Patients said they gave consent to care and treatment and any changes, risks and benefits were discussed with them. Families of patients too unwell to consent told us they were included in the discussions and gave consent on behalf of their family member. Patients told us that the doctors explained everything to them when they became well enough to understand what they were going through.

Emotional support

- We were told that emotional support was provided to patients and families by all members of the critical care team.
- Relatives and friends of patients told us the staff enquired after their well-being and reassured them when visiting the unit. One visitor told us: "The staff have helped make it less scary to visit. They have encouraged us to speak to our friend and hold their hand."
- The unit had access to the chaplaincy service that covered all major world religions.
- We were aware of a patient who was known to suffer from depression and was finding it hard to engage and communicate with staff. Staff were aware that the patient had low moods and was finding their circumstances frustrating. We heard staff being reassuring and trying to understand the patient.

Are critical care services responsive?

Good

We judged the service delivered in the CCU at West Middlesex University Hospital was responsive to patient needs.

Patients who used the services received critical care treatment within four hours of referral. The unit admitted 54 patients in November 2014, of which four were delayed. From January 2014 up to our inspection the unit had 503 discharges to hospital wards. Of those, 234 (46.5%) were delayed discharges because of bed availability in the rest of the hospital. Another 15% of patients were discharged earlier than ideal because ICU or HDU beds were needed for someone with a higher dependency. The unit tried to avoid discharging patients out-of-hours. However, they reviewed patients' needs on a daily basis, and identified those that could be discharged out–of-hours should it be necessary. However, this did not affect patient care and treatment.

Critical care

A consultant was available on the ward every day for patients or relatives to talk with. There were protected sleep and visiting times. However, visiting time were flexible if required by visitors and appropriate to the patient's care and running of the unit.

There was access to multi-faith chaplaincy and translation services. The service took account of people's complaints or concerns at the time of it being raised whenever possible. They took into account patient and relative views and gave us examples of changes they had made as a result.

Service planning and delivery to meet the needs of local people

- In line with the core standards for intensive care units guidance the CCU followed the closed model of intensive care, which has been shown to improve mortality and morbidity. The closed model of intensive care means that all the patients' care needs are supported by the doctors and nurses on the unit, and not provided by the doctor who has admitted them to the unit. The unit doctors would inform the admitting doctor of their patient's care and treatment programme.
- There was an information leaflet available for patients and their relatives about what to expect when being admitted to ITU or HDU, being discharged and rehabilitation.
- The unit gave patients and their families a paper format survey to complete after being discharged from CCU. Staff told us one of the criticisms of the unit was the lack communication. The consultant told us that as a result of this issue that, on top of the formal conversations regarding their relatives condition, they will have more ad hoc and informal conversations. Nursing staff were also informed to let patients know that they can speak with a consultant at any time.

Access and flow

- The unit had nine critical care and five high dependency beds that served a local population of approximately 400,000 people.
- Cases admitted through A&E took priority over planned cases of elective surgery. In the last six months 12 cases of elective surgery had been cancelled due to a lack of ITU beds.
- The ITU consultant managed and co-ordinated all admissions to ITU and HDU, discharges to the wards and arranged transfers to other units where necessary.
- The outreach team assisted and supported ward-based colleagues in the early identification of patients at risk of deteriorating and who may require an HDU or ITU bed. The team also identified level one and two patients located in the main hospital wards who needed supported nursing staff.
- National guidance suggests that patients who require intensive care treatment should receive it within four hours of referral. In November 2014 the unit had 54 admissions, of which four (7.5%) patients were delayed.
- The management team told us they would not elect to discharge patients from the unit to the wards out-of-hours.
- Staff reported a high number of delayed discharges with a significant number occurring overnight due to poor bed availability. Of the out-of- hours discharges 85% were due to lack of beds available on the ward, while 15% of out-of-hour discharges related to patients who were discharged earlier than ideal in order to release a bed for a newly-admitted patient with critical needs. This contrasted with the reported ICNARC figure for late night discharges that scored 0%.
- The bed management team had daily discussions to identify patients who could be discharged early should a bed be required urgently. The night team were given the names of these patients should an emergency arise. Patients discharged out-of-hours were picked up on the wards by the critical care outreach team the following morning.
- There had been one non-clinical transfer in the last six months due to lack of capacity on the unit.
- Emergency patients were not discharged home from the unit, but transferred to a medical or surgical ward to be discharged from there. Patients who had elected to attend treatment at the hospital and had continuous positive airway pressure (CPAP) treatment available at their usual home could be discharged after a night in ITU or HDU without being transferred to another ward.

Meeting people's individual needs

- Staff were very professional and good at dealing with patients with complex medical needs. They were reassuring and displayed empathy to patient who was unconscious in ITU.
- We saw that TVs were available for people who were conscious and needed some stimulation. However, we noted that this was not offered to a patient on in ITU

who was conscious and finding it difficult to communicate their needs and wishes. We asked how they were feeling and they indicated to us they were bored.

- We asked staff how they communicated with people who had a tracheostomy in place. They told us they did the best they could but it was not easy. We asked if there were any pictures or words that patients could point to in order to try and communicate. Staff found an alphabet and page with phrases to describe things such as pain, thirst or toileting needs. But, they had not thought to try using it to communicate with patients who could not speak. Staff had access to a speech and language therapist to help.
- A number of staff on the unit and in the hospital spoke a range of different languages and could be used to communicate with people who did not speak English as their first language. Translation services were available through language line (a telephone service) and interpreters could be arranged with some notice.
- Patients' spiritual care was taken into account, and the hospital had access to a multi-faith chaplaincy that was available 24 hours-a-day.
- Although relatives were asked to keep patients' property to a minimum, we noted that families were able to bring in personal items to the patient such as framed photographs, cosmetics and fragrances that made them feel more like themselves.
- There was a reception area available for visitors with a drinks machine and toilet. Restaurants, shops and other facilities were available in the hospital. There was a consultation room where private discussions could be held.
- The unit promoted protected sleep times for patients, and most of the patients said they were able to sleep. However, we found some of the environment was not quiet such as when the bins were opened and closed causing a disturbance.
- Patients and their friends or family could telephone the unit at any point to speak with staff about their family member. However, the unit did not have a dedicated ward clerk to take calls or deal with administration. When the unit nurses were busy the phone would divert to an answer phone for staff to follow up at a later stage. Staff felt that this was not an effective way to work and could leave callers frustrated and worried.

Learning from complaints and concerns

- There was evidence that the service had learnt from comments and complaints. The most recent one related to communication between the consultant and patients/family. The consultants told us they always spoke with families when there had been a change in their relative's care prognosis, but they generally did not have informal chats. They told us they usually spoke with families whenever they saw them visiting as a way of checking how they are and whether there was anything they wished to ask. These conversations were not documented because they were ad hoc.
- Staff told us they would address any concerns or complaints raised in the unit instantly and entered into open discussions with patients and their loved ones.
- If conversations became too challenging because of their emotional nature, staff would seek input from other senior colleagues to provide an alternative approach.
- We saw a large number of thank you cards displayed at the entrance to the unit and saw a previous patient visit with chocolates and a card thanking staff for all the care and attention they had received.
- A leaflet on how to complain or make comments about the service was available in the reception area.

Are critical care services well-led?

Good

We judged the ITU and HDU at West Middlesex University Hospital was well-led.

We found effective governance structures. Risk registers demonstrated that risks were identified, recorded and actioned. Risks were closed once completed, although it was hard to identify how long risks had been on the register and therefore how efficiently they had been actioned. Staff and patients were asked for their view of the service provided.

Although there was uncertainty about the unit's expansion as part of future plans for the local health economy, the team remained focused on delivering high quality, safe and effective care to patients. The team remained loyal to one another and the hospital. Staff reported being involved in local decisions making about the unit, and told us they felt supported by each other and their immediate manager on

the unit. However, more senior management expressed some concern about how well informed and included they were in decision-making about the unit and the division's future structure.

Vision and strategy for this service

- The senior management, senior nurses and consultants were all committed to their patients, staff and unit. The vision of the unit was to provide the best outcome for seriously ill patients through high quality care provided by highly trained professionals. The unit's staff described the aim was to provide a first-class service. A number of patients and their relatives also described the unit as "first-class".
- The Shaping a healthier future programme (SAHF) was set up to improve healthcare for people living in North West London. Senior staff voiced an aspiration to provide outreach services in the hospital 24 hours-a-day, seven days-a-week.
- The management team had a vision for the expansion, but no clear agreed view of what it would look like in reality. There had been little communication from the SAHF team about what would be implemented.
- Senior staff had been involved in discussions and the plans relating to staffing levels, equipment and the layout of the unit. Staff we spoke with were aware of the future proposals for the unit and felt informed and reassured about their future by their immediate managers.

Governance, risk management and quality measurement

- The CCU did not have direct representation on the trust board. They were represented through the surgery division.
- Risks relating to the ITU and HDU were fed into the surgery division risk register, which was reviewed on a monthly basis at the Q&R meetings.
- Morbidity and mortality was fed into the division meeting for surgery and critical care.
- The unit took part in recommended audits as well as measuring quality in other areas. The unit had a band 7 nurse who was responsible for the audits the unit participated in.
- Staff were responsible for local checks such as: recording the pressure for the negative pressure room; drug fridge temperatures; and the resuscitation trolley. However, we found gaps in the records, some of which were due to the absence of the responsible staff member and no one else performing the task in their place.
- Staff played an active part in contributing to how the unit was run, such as the monthly meeting where they proactively set the agenda. Staff who had raised any items for discussion and were unable to attend the meeting could ask their line manager to raise the topic on their behalf. These meetings were also used as an opportunity to discuss and remind staff of risks and best practice.
- All the staff we spoke with were aware of the outcome of the audits and the main challenges or concerns for the unit.
- There was evidence of new procedures being put in place in response to an incident in another part of the trust. The records we reviewed in response to the incident showed that a new proforma was used and completed.

Leadership of service

- We found evidence of strong leadership in the service at a local level. It was clear from our conversations that the staff had confidence in the leadership at a local level. Staff reported feeling supported by their teams and immediate line managers. They told us they were kept fully informed of anything that related to them in their role or related to the unit.
- Staff spoke positively of the new director of nursing. They were reported as being visible and approached concerns not only from a management perspective but from a nursing one too.
- However, the senior managers in the surgery division did not feel as fully informed by their managers about the future of the unit and the division. The reporting structure for the surgery division was due to change in January 2015, and senior staff reported that they had not been included in discussions about this. They felt that they had not been able to share their thoughts and ideas or discuss any concerns about how it would affect them.

Culture within the service

- The nursing and medical staff often went above and beyond what was required from them. Senior staff told us they quite often had to remind staff of the importance of taking their breaks. Staff on occasions worked beyond the hours expected of them to provide

continuity of care and ensure safe handovers. We saw senior nursing staff leaving their shift up to an hour late to ensure the senior nurse coming on shift was aware of the status for all the patients on the unit.

- There was an established MDT and inclusive culture in the unit. We spoke with a pharmacist, dietician and physiotherapist who visited the unit daily. They told us they felt fully integrated into the unit and they could discuss patients' care with the nursing and medical team. They reported that their recommendations were listened to and acted on.
- We found the team in the unit were a strong and cohesive team. It was evident that a clear, open and transparent culture had been established, we saw that nursing staff felt confident to challenge doctors on infection prevention and control. The senior staff told us that the nursing staff would always speak with them if they had any concerns or issues relating to a patient.
- There was a nursing team event held once a year for each team. It was an opportunity for staff development, education and team building,
- The unit held an annual family fun day and 70 staff attended the last event. Staff said that this was a great way to build the team and made them feel valued. Lunch was provided on the unit for staff who were unable to attend because of working on the day so that they did not feel left out.
- Nursing staff told us the managers were considerate of any personal issues and were flexible in arranging shifts around personal commitments whenever possible.
- The unit staff were highly complimentary of each other. The senior staff described the nurses as "excellent and very good communicators" and the doctors as "very good and consistent". Junior staff and temporary staff described the substantive staff as "supportive and very helpful". All the staff told us they did not have any concerns seeking support of advice from the senior staff and managers of the unit.
- There was a photo board at the entrance to the unit showing the staff structure for the unit. All the nursing and medical staff had their photo and name included. The intention was to include other regular staff in the unit such as the dietician, pharmacist and domestic staff.

Public and staff engagement

- Staff told us they could attend meetings with the chief executive and other members of the senior management team.
- Staff gave us examples of ideas they had to improve patient safety, care and experience and how these had been implemented in the unit.
- Staff told us the hospital had regular staff and patient experience events where they could listen to the patients' experience of the hospital.
- Patients and their relatives were asked to complete an ITU/HDU feedback form. We were told that the completion and return of the forms had increased from six out of ten to eight out of ten.
- Staff gave us of examples of how they had made changes as a result of patient feedback. Changes included employing a volunteer to staff the reception desk on Saturdays to make access to the unit easier. They were still trying to find a volunteer for Sundays.

Innovation, improvement and sustainability

- All the staff we spoke with agreed that the unit had a core of stable staff and low levels of short-term staff sickness. Permanent staff on long-term absence were supported in returning to work and had a returning to work interview with their team leader.
- We were told there were a high number of agency staff used to fill absences, and that this could cause difficulties for the permanent staff because it increased pressure on their normal workload. Senior staff told us there was a national problem with recruiting staff to critical care. They actively recruited newly-qualified staff who had shown interest in critical care during their work placements. The unit also had strong links with universities and explored the recruiting staff from overseas.
- The future expansion of the critical care unit at West Middlesex University Hospital and amalgamation plans with Chelsea and Westminster had stopped the unit looking at any innovative ideas or ways to enhance the patient experience. However, the staff we met were committed and motivated in continuing to provide a high quality service to patients, and had a loyal attitude to their colleagues, the unit and hospital.
- Implementing nursing teams that worked together regularly and consistent consultant cover in the unit meant that there delay to patient care were reduced and admissions faster.

Critical care

- The unit had adapted a “best practice approach” to patient management, which meant that all patients were assessed every day against a set of interventions with an evidence base that demonstrate that they improve outcomes for critically ill patients.
- The unit had made submission to be involved in national projects and research, but as yet had not been successful at winning the work because of their small size.

Maternity and gynaecology

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

Information about the service

The West Middlesex University Hospital NHS Trust maternity unit is in the Queen Mary maternity building next to the main hospital, equipped for 5,000 births annually. At the time of our inspection building work was taking place to expand the unit. This was due for completion by January 2015.

The maternity building entrance leads to: a reception area; a four-bedded triage ward; an 18-bedded antenatal ward; a 10-bedded labour ward; and a four-bedded midwife-led natural birth centre with two birth pool rooms. The two obstetric theatres and a recovery area are situated next to the labour ward. There are also two high-dependency rooms next to the labour ward. The antenatal clinics and the specialist outpatient clinics, such as the diabetic clinic and specialist gynaecology clinic which is on the first floor of Twickenham House. The six teams of community midwives have their office in the same building. The 30-bedded postnatal ward and the special care baby unit (SCBU) are on the first floor.

The gynaecology outpatients department is located on the first floor of Twickenham House, a standalone building to the right of the main hospital. There is a dedicated bay on Richmond ward in the main hospital for inpatients and patients that require surgery. The majority of gynaecological operations are performed in the day surgery unit in the main hospital. The early pregnancy unit is situated in the main building.

We spoke with nine patients, four relatives and 37 staff that included: consultants; doctors; midwives; nurses; other healthcare specialists; and support staff. We observed care and followed the post-operative case notes of two patients, and looked at the care records and patient notes of mothers in the postnatal ward. We reviewed other documentation, which included performance information provided by the trust. We received comments from patients and those close to them, and from people who contacted us to tell us about their experiences.

Maternity and gynaecology

Summary of findings

We found the midwifery staffing level in the maternity and gynaecology service requires improvement. Women and patients attending the unit had been exposed to the potential risk that they could have received inappropriate care and treatment.

Our inspection confirmed there were insufficient suitably qualified, skilled and experienced staff employed throughout the midwifery and gynaecology service. The service had relied on staff working overtime, often unpaid, and on bank (staff who work overtime in the trust) and agency staff to support day-to-day operations. Even so, we found insufficient experienced midwives and nurses on shifts. There was little spare capacity to cater for emergencies for patients with complications and for staff going off sick.

Sometimes staff were not fully skilled to do their jobs safely and efficiently, and skilled staff were not always used effectively. A midwife treating patients in the obstetrics high dependency unit (OHDU) was not OHDU-trained, which was in violation of the trust's own protocol for the OHDU. Two-out-of-four midwives rostered for a shift in the postnatal ward had little post-qualification experience. A nurse in the early pregnancy unit (EPU), one of only two staff on shift, was not trained in obstetrics and was not able to take blood. The EPU had problems with both the number and skill mix of staff. It also suffered from vacancies in three key posts (two consultants and ward sister) because two staff had left and one was on long-term sickness leave.

Patients who needed one-to-one care because they were in labour or required high dependency care sometimes did not receive it because of the staff shortages. The OHDU suffered from both understaffing and inadequately trained staff.

Some women with ante partum complications (complications during birth) had to wait to be induced because there were not enough midwives available at the time. This delay could impact on the safety of the baby in utero.

There were considerably more maternity inpatients per midwife than the national average, which could have adversely affected the women's care and treatment. In addition, the maternity dashboard suggested that the trust had been working to an incorrect target for this aspect of care. There were plans to recruit eight midwives a year across the maternity department over several years to correct the staffing shortfall. However, the situation demanded more speedy resolution.

We found women generally felt well informed, and they were given the choice of a range of options for birth that included birth in a midwife-led natural birth centre, subject to an appropriate risk assessment. Most women and their partners were complimentary about the staff and their caring attitude. However, some expressed disappointment that there were not enough staff available to assist them when they most needed help.

There was consultant cover for the maternity service seven days-a-week, supported by each consultant's team of registrars, senior house officers and junior doctors. Staff followed good clinical care pathways using evidence-based national guidance. There was effective multidisciplinary (MDT) working in the maternity department, with other services in the trust and with external organisations.

Specialist midwives were available to support women with complex healthcare needs and women with mental health issues were well supported by the perinatal mental health team. There was a good bereavement support and counselling service. Midwives felt supported by their line managers and supervisors of midwives and staff development and continuing professional development had been encouraged.

Maternity and gynaecology

Are maternity and gynaecology services safe?

Requires improvement

The maternity and gynaecology services had reported three Never Events (series, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) between April 2013 and May 2014. These all related to retained swabs in two cases and a retained tampon in one case. There had been a serious incident in September 2014 that had resulted in a patient being transferred from the maternity unit to the intensive treatment unit.

Incidents had been reported through Datix (patient safety incident software reporting system). However, there was under reporting of incidents by staff.

A monthly maternity dashboard was used to highlight performance against safety-related targets. However, when we examined the maternity dashboard data from November 2013 to October 2014 we found inconsistencies in the construction of the dashboard spreadsheet.

There were insufficient suitably qualified, skilled and experienced staff employed throughout the midwifery and gynaecology service. The service had relied on staff working overtime, often unpaid, and on bank and agency staff to support the day-to-day operations. However, we found insufficient experienced midwives and nurses on shifts. There was little spare capacity to cater for emergencies, for patients with complications and staff going off sick.

Patients requiring one-to-one care because they were in labour or because they needed high dependency care sometimes did not get it because of staff shortages.

Some women with intrapartum complications had to wait to be induced because there were not enough midwives available at the time. This delay could impact on the safety of the baby in utero.

There were considerably more maternity inpatients per midwife than the national average, which could have adversely affected the women's care and treatment.

Staff sickness was a problem. There was a very high rate of staff sickness in the gynaecology department, averaging 23.04%, the maximum being 31.54% in August 2014.

The deficiencies in the number and skill mix of staff had placed women and babies at risk of not receiving safe care and treatment. This had affected patients who required critical care in the labour ward and OHDU.

Consultants were on duty seven days-a-week, supported by a team of registrars and junior doctors who were on site out-of-hours. Both doctors and midwives considered they worked in supportive teams.

The maternity service used the NHS Safety Thermometer to support the provision of safe care for women. This was used along with other measures to assess safety.

The service used a modified early warning score (EWS) chart to measure patients' condition and to determine when prompt treatment was required.

Medicines had been appropriately administered to women in the maternity service and accurate records had been kept. Patient records had been appropriately maintained and staff adhered to the trust's policy on confidentiality.

The wards were clean and uncluttered. Equipment was appropriately checked and cleaned and had been serviced regularly. Building work was in progress to expand and improve the maternity facility.

Incidents

- There had been three Never Events in the maternity and gynaecology service between April 2013 and May 2014. Two of the incidents were related to retained swabs and one incident related to a retained tampon.
- The first incident occurred in August 2013. An agency midwife had left in a small swab. The incident had been investigated and an action plan had been drawn up. All small swabs in delivery packs had been replaced with five x-ray detectable non-tailed swabs. A new protocol was also introduced in October 2013, which required two midwives to count all swabs in the delivery or perineal packs before and after use, and to complete a swab use form.
- The second incident occurred in March 2014. A midwife had placed a tampon to stop a bleed, but it had not been removed later. The investigation concluded that the midwife involved had not followed the new protocol introduced after the first incident.

- The third incident occurred in May 2014. A consultant left in a swab in theatre. The incident had been investigated, and the theatre team had been given extra training and instructed on how to ensure the swab count protocol was followed appropriately.
- No external review took place.
- There have been no Never Events from June 2014 to the present time.
- The quality and risk (Q&R) monthly update for December 2014 issued by the trust's integrated governance department showed there was a serious incident in September 2014 that resulted in a patient being transferred from maternity to the intensive treatment unit (ITU).
- There was openness and transparency when things went wrong. Staff confirmed root cause analysis had taken place and themes from incidents had been discussed at team meetings, focus groups, safety and other meetings.
- All staff we spoke with said they reported incidents using Datix. However, our intelligence monitoring indicated there had been potential under-reporting of patient safety incidents over the period February 2013 to January 2014. We noted the minutes of the gynaecology morbidity and mortality (M&M) meeting dated 24 October 2014 stated: 'Still not enough Datix incidents being reported.'
- Members of staff we spoke with confirmed they had not always reported incidents through the Datix system. One member of the medical team had highlighted cases of where midwifery staff had omitted to carry out clinical vital signs observations and recording for women who had been unwell. However, this had been reported only once, although there had been more than one occasion when such an incident had happened within the last four months. Since incidents had been under-reported by staff, the statistics on the occurrence of different categories of incident will not be accurate.
- Gynaecology M&M meetings had been held monthly.

Safety thermometer

- The service used the NHS Safety Thermometer to support the provision of safe care for women in the antenatal and postnatal wards. The monthly charts in both wards for October 2014 indicated: no hospital-acquired pressure ulcers; no fall incidents; no catheter-related urinary tract infections; and no venous thromboembolisms (VTEs). Patients at risk of VTEs had received appropriate prophylactic treatment. This showed that the maternity service had passed a very simple safety test based on four indicators on the Safety Thermometer. This was used along with other measures to assess safety.
- A monthly maternity dashboard highlighted performance against safety-related targets. The indicators used included clinical activities such as the percentage of: caesarean sections and instrumental deliveries; clinical outcomes such as third/fourth degree tears; intensive care unit admissions in obstetrics; workforce indicators such as the birth/midwife ratio; the percentage of women receiving one-to-one care in labour; and mandatory clinical training for midwives and medical staff.
- We examined the maternity dashboard data for the year to October 2014 and found inconsistencies in the construction of the dashboard spreadsheet. This was due to errors in either certain target conditions or the associated highlighting. This applied to the number of cases of shoulder dystocia (where a baby's shoulder near the front gets stuck behind the mother's pubic bone); the number of term intrauterine deaths/ stillbirths; the number of cases of meconium aspiration (a medical condition affecting newborn infants); the number of neonatal deaths at term; the number of serious incidents; and the number of complaints.
- We have made the conservative estimates about the following targets, which should be: shoulder dystocia less than or equal to three per month; term intrauterine deaths/stillbirths nought per month; meconium aspiration less than or equal to one per month; neonatal deaths at term nought per month; serious incidents nought per month; and for complaints less than or equal to one per month.

Cleanliness, infection control and hygiene

- All the ward areas, including the labour, postnatal and antenatal wards and the obstetric and gynaecological outpatient units, were clean and tidy. Although building work was in progress for the new extension to the antenatal ward and the natural birth centre, this did not affect the hygiene standard in practice.
- We noted separate hand washing basins with hand wash and a dispenser for disinfectant gel were within easy reach, and were available in all the units. We saw staff regularly washing their hands and using disinfectant gel between patients.

- Personal protective equipment (PPE) was available for use by staff in clinical areas. We observed staff wearing PPE such as disposable aprons and gloves when required.
- Staff wore clean uniforms with arms bare below the elbow as required by the trust's policy.
- There had been no recent cases of Clostridium difficile or MRSA infection.
- There was a lead midwife for infection control who ensured staff adhered to the hygiene code of practice and the trust policy on infection control.
- Since our last inspection in 2013, improvements had been made to cleaning. This included a new sign-up sheet with the date and time of cleaning, and the signature of the designated cleaner in every room to provide evidence of the daily cleaning regime. Areas included on the sign-up sheet were: toilets; bathrooms; sluices; and the clinical waste disposal facility. The forms had been correctly filled in by staff.

Environment and equipment

- The environment in the labour, antenatal and the postnatal wards was clean and generally uncluttered, except where building work was in progress. Women, visitors and staff said they had got used to the building work and were not unduly affected. People's safety had been maintained.
- Work was in progress to build two new birth pool rooms to replace the two existing ones in the natural birth centre. Five new en suite antenatal rooms were under construction to replace a section of the existing antenatal ward. The existing rooms would be used to house other facilities.
- We observed that equipment was readily available and had been appropriately cleaned, checked and serviced. In the labour ward, for example, the equipment in use was visibly clean and dust free.
- Each clinical trolley was covered with a plastic sheet and clearly labelled. For example, the equipment trolleys for foetal blood sampling, eclampsia, post-partum haemorrhage, epidurals and instrumental delivery were properly labelled. We noted a member of staff was thorough in checking the contents of each trolley against the checklist, which was signed and dated daily when the checks had been completed. We saw that broken equipment was labelled and reported for repair.
- The resuscitation trolleys in the labour ward for both adults and neonates were checked daily by a designated midwife and appropriately labelled. We saw the checklist and records that had been filled in daily and signed by a member of staff. We checked the packs of syringes and needles, sterile delivery items and sutures and found they were all in date.
- The cardiotocography (CTG) electronic equipment used to monitor foetal heartbeat and uterine contractions during labour was in good working order.

Medicines

- Medicines were stored in drug trolleys in the postnatal wards, and stock medicines were stored in locked cupboards in the staff office/station. All drug cupboards, drug boxes and fridges for medicines were locked when not in use.
- Controlled drugs were checked daily and fridge temperatures were monitored and recorded correctly.
- We saw medicines had been appropriately administered to women in the postnatal ward and accurate records had been kept. The trust pharmacist audited the drugs in stock and restocked the drugs in each ward daily. Members of staff confirmed there had been no errors in drug administration in recent months.
- At weekends patients or family regularly have to return to the ward the next day to collect their discharge prescription if medicines are not available as TTA (to take away) packs.

Records

- People's records had been maintained by staff in the maternity department. We looked at some people's care notes and observation charts and found them detailed and appropriately maintained.
- We observed that standard risk assessments for patients had been undertaken, such as the risk of falls, Waterlow scores (risk assessment scoring system) for pressure areas and the malnutrition universal screening tool (MUST) score for nutrition. The records showed that these assessments had been carried out on admission and reviewed when the patient's condition had changed.
- People's clinical notes were in paper format and were kept in lockable trolleys in the office. Confidential information was stored securely in the office.

Safeguarding

- The service had clear safeguarding processes in place and staff had an awareness of the importance of safeguarding people from abuse and harm. There was a

named midwife who dealt with safeguarding matters and who ensured staff followed the safeguarding procedures. There were plans to improve the flowcharts for the processes to be followed.
- The staff we spoke with were able to explain what would constitute abuse of mothers or babies. They were able to tell us the actions they would take in the event of witnessing abuse.
- The midwives were aware of the problem and signs of female genital mutilation.
- There were good processes for handovers to the SCBU and the multi-agency team including the social care and foster care services and the local authority that would take the lead in safeguarding investigations.

Mandatory training
- Midwives' compliance with mandatory clinical training stood at 91%. They told us they had received yearly statutory and mandatory training, which had included online and multidisciplinary components.

Management of deteriorating patients
- There was an escalation protocol available to ensure patients who were unwell received appropriate attention. The service used a modified maternity obstetric early warning score (MOEWS) chart that gave staff directions about how to escalate care in the event of a patient whose condition was deteriorating. The modified chart used the colour coding: red; white; and amber. If a vital signs observation was marked amber, the senior house officer was informed and the patient seen in an hour. If the observation was red, the patient would be seen by the registrar within 30 minutes. If the oxygen saturation reading was in the red, the anaesthetist was called to see the patient within 30 minutes. We looked at completed charts and staff confirmed they had escalated cases appropriately.
- The maternity risk management team was currently reviewing the MOEWS chart because the protocol only covered its use in the OHDU, but staff had been using the chart throughout the maternity wards. There was no space on the chart for the member of staff who completed it to enter their signature. This identification was vital to track cases.
- Staff used a modified World Health Organization (WHO) surgical safety checklist in the obstetric theatres. An audit undertaken by the risk management midwife confirmed the checklist had not been completed fully. A new form was introduced in November 2014, and the risk group will be carrying out further audits.
- A monthly clinical governance and risk management meeting was held to consider any incidents reported through the Datix system. The team reviewed clinical practice and lessons learned and recommended actions to take to improve the service and the standard procedures.

Midwifery staffing
- The maternity dashboard for the year to October 2014 showed the average number of maternity inpatients per midwife had been 36 from March 2014 to the present time. Before March 2014 the number had been 37. Both figures were well above the national average of 29. This showed there had been an insufficient number of midwives employed in the maternity unit for a long period of time. Further, the maternity dashboard figures revealed that the trust target for 2013/2014 was 37 or fewer. This target was well above the national average. This indicated the maternity department did not employ a sufficient number of midwives. Women and babies had been exposed to the risk of receiving unsafe and inappropriate care and treatment.
- We were told the trust had used the private sector Birthrate Plus (BR+) Consultancy three times in the past to calculate the required static staffing level. The BR+ audit for April to June 2014 showed a shortfall of 17.6 whole time equivalent (WTE) midwives, and nine WTE too few maternity assistants. The figures were based on the hospital's current birth rate of 4,774 for the year 2013/2014. The service was planning to use the BR+ Acuity Assessment for Risk Management tool to provide real-time data about staff needs on a shift-by-shift basis.
- The business plan for the trust showed they intended to recruit eight midwives a year until 2017 to bring the ratio of midwives to inpatients to 1:30. We have yet to see the impact of this change on the staffing.
- Although bank and agency staff were also used, staff told us this was not always possible because bank or agency staff were not always available. It was also difficult to make last minute arrangements when members of staff went on sick leave at short notice. This was the case at the time of our inspection.
- Several members of staff told us they usually worked unpaid hours to ensure they gave women the best

possible care. They said they often delayed going off site when their shift had finished. Sometimes there were no staff to take over from them. Staff told us the service had often depended on the goodwill of staff to work extra hours without payment. The trust stated that it gave time off in lieu of extra hours.

Staff sickness

- The rate of staff sickness in the maternity department between June 2014 and August 2014 averaged 3.30%, and was rising. It had reached 4.52% in August 2014.
- We were told there were 17 midwives on maternity leave at the time of the inspection.
- The rate of staff sickness in the gynaecology department over the same period was very high at an average of 23.04%. The maximum rate had been 31.54% in August 2014. The high level of staff sickness might be symptomatic of endemic problems in the gynaecology department.

Staffing in the early pregnancy unit

- The EPU is part of the gynaecology department. It treats problems in the early stages of pregnancy.
- **Workload.**The consultant for the unit confirmed that 125 to 150 women had been seen each week. No audit had been carried out yet. We were told the unit had formerly been scanning 200 cases a week for approximately a year, but scanning had recently become more challenging.
- **Under-capacity.**On the day of our inspection, 18 of the women attending had to be asked to return another day because of under-capacity in the service. Although women who required emergency treatment in the EPU had always been seen, while others had to be turned away until the next available session. This meant a longer waiting time for women who needed a scan. Also due to staff sickness, the EPU currently received only sporadic support from the maternity service sonographer. The service was not robust enough to cope with increased capacity. The trust had plans to recruit more staff specifically for the EPU. It remains to be seen what impact this will have on the staffing shortfall.
- **Staffing numbers and skill mix.**Staff told us there were issues with the staffing numbers and skill mix of nurses in the unit. We were told the EPU was routinely staffed by an experienced nursing sister and a nurse, who might have little or no experience in obstetrics or gynaecology. We found an example of an orthopaedic nurse working in the EPU who was not trained to take blood. At the time of our inspection the nurse was a bank, band 5 nurse.
- **Staff leaving and retiring.**The general manager confirmed that a consultant would be leaving in December 2014 and another in March 2015. We were also told both consultants would be helping part-time from January 2015 to ease the pressure. A new consultant would be joining in early 2015. The general manager assured us that locum consultants would be employed to provide cover in the meantime. We have yet to see the impact these changes will have on the unit.
- **Long-term sickness.**We were told the lead sonographer had been on long term sick leave and there was sporadic support from a sonographer from the maternity service. The obstetrics and gynaecology scanning service had been on the risk register for some time.
- **Recruitment.**The general manager assured us the trust was recruiting for the unit and had advertised for two band 5 nurses two months ago, and for a band 6 nurse three weeks ago before our inspection visit. A qualified band 5 nurse would be starting on in mid-December 2014.We have yet to see the impact of these arrangements on the care and treatment of women attending the unit.

Staffing in the antenatal ward

- **Night.**We inspected the antenatal ward on the night of 27 November 2014. We were told the ward was covered by two midwives (a band 6 and a band 5), and one healthcare assistant (HCA). They were supported by an agency midwife. At the time, there were 12 women in the 18-bedded ward.
- However, at around 10pm that night staff were asked by the labour ward co-ordinator to monitor a woman who had been admitted with complications, and who required augmentation as soon as the labour ward staff were available to care for her.This indicated that there was an insufficient number of staff working in the labour ward. Women and babies had been exposed to the risk of receiving unsafe care and treatment.

Staffing in the labour ward, the natural birth centre and the triage unit

- **Shifts.**Staff working on the day shift usually worked a 12-hour shift from 7.30am to 8.30pm with an hour break. The night staff worked from 8pm 7.45am. Other shifts were from 7.30am to 3pm and from 1pm to 8.30pm.
- **Day.**We were told there were usually a manager and eight midwives to cover the labour ward, the natural birth centre and the triage unit.
- **Night.**On the night of our visit on 27 November 2014, six staff were on duty in the labour ward: the midwife co-ordinator; another band 7 midwife; a band 6 midwife; three agency midwives; and an HCA. Two of the agency midwives were regular workers. We noted the midwife co-ordinator was the only midwife on duty trained in high dependency maternity care. The team were covering a 10-bedded delivery suite, plus two beds in the natural birth centre.
- **Day, in the natural birth centre.**Two midwives were allocated to the natural birth centre. On three days-a-week the centre was covered by a band 7 midwife and a band 6 or band 5 midwife. On other days the centre was covered by a band 6 and a band 5 midwife. This was the case on the day of our inspection. On some days there were also two midwifery students working there. Currently two of the four delivery rooms were closed due to building work. On the day of our inspection there was no admission to the centre.
- **One-to-one care in labour.**The target minimum percentage of women receiving one-to-one care during labour was 90%. The Trust achieved the target every month except for January 2014 when it was 88.9%.
- Midwives we spoke with expressed concern about the ratio of midwives to women in labour. One commented: "It was a challenge to strive for each woman to have a named midwife during labour because of an insufficient number of midwives on shift." Staff confirmed that at times they did not achieve this aspect of care. One midwife commented: "I am impressed at times to have managed to give one-to-one care. While another midwife said: "On the whole, we provide safe care, but I don't think I can give that little extra to women as I would love to do because of shortage of staff."
- **Delayed treatment.**One woman, a new admission, was waiting to be augmented because of complications with the birth. She was being cared for and monitored in the antenatal ward until the labour ward staff were available to take over. It was not clear how long the woman had to wait before being transferred to the labour ward for imminent augmentation. The band 7 midwife co-ordinator in charge of the night staff had informed the on-call supervisor of midwives of the situation. At the time of our visit the co-ordinator was busy phoning around for additional agency midwives, and had also checked with some off-duty midwives to see if they were available to work the night shift, but without success. Although the labour ward was not full, it was clear there was an insufficient number of midwives on site to cover emergency admissions and any complications that might arise. The co-ordinator was spending too much time phoning around when they should have been giving clinical support to staff, particularly given the complexity of some women's conditions at the time. It was foreseeable that more staff should have been allocated at the beginning of the night shift to cover for emergencies. At the time of our inspection the 10-bedded delivery unit and two delivery rooms in the natural birth centre were also in use. The natural birth centre had two further birth pool rooms which were closed due to building work. We were told the trust did not have managers or experienced midwives on-call at night to cater for emergencies.
- The labour ward had an insufficient number of midwives on night duty. Women and babies had been exposed to the risk of receiving unsafe care and treatment.

Staffing in the obstetrics high dependency unit

- **Night.**We inspected the OHDU on the night of 27 November 2014. At the time we were told one woman had delivered in the labour ward, but had been transferred to one of two high-dependency beds in the OHDU because she required one-to-one care and observation. We noted the midwife looking after her was an experienced band 7 midwife, but not OHDU-trained. There were four other women in labour, with one in the high risk category. Another woman had delivered and would be transferred to the postnatal ward when it was safe to do so.
- **Skills needed.**The protocol for the OHDU states that women needing level 2 care require a minimum staffing ratio of one-to-one. It also states that OHDU expertise is provided by midwives or obstetric nurses who have had: critical care unit (CCU) training/experience; midwives who have undertaken a high dependency care module; or senior midwives who have had extensive experience of high dependency maternity care. The midwife

co-ordinator confirmed the midwife allocated to OHDU was an experienced band 7 midwife, but had not undertaken training in a high dependency care module. This might have had an impact on the safety of the women in need of specialist care. The fact that there was an insufficient number of midwives on duty together with a less than optimal level of skill mix, women in labour and women requiring specialist one-to-one care were exposed to the risk of receiving unsafe and inappropriate care and treatment.

Staffing in the postnatal ward

- **Night.**We inspected the postnatal ward on the night of 27 November 2014. We had been told by staff of all disciplines that the staffing level of two trained staff at night in the postnatal ward was inadequate, particularly when the ward was full. We were also told there was often a trained midwife and one obstetric nurse on duty supported by two HCAs. When we visited the 30-bedded postnatal ward at 9pm we confirmed the staff consisted of one band 6 midwife, a band 5 obstetric nurse and two HCAs. There were 18 women being cared for, some with their babies. Some of these mothers were first-day, post-operative caesarean section patients. The staff were managing the ward well because it was not full. However, this might not have been the case if the ward was full.
- **Day.**When we visited the postnatal ward at approximately 9.30am on 28 November 2014 we found that four midwives had been rostered for the shift, a bank midwife who took charge and three other midwives. Two of the rostered midwives were band 5, with little post-qualification experience. Two midwifes went off sick. A band 6 midwife from the labour ward had been reassigned to the postnatal ward for the shift. There were therefore three midwives instead of four working the shift. The postnatal ward had more than 18 women, some with their babies. Some of them were recovering from surgical operations such as caesarean sections. The postnatal ward was understaffed, and this might have exposed women and babies to the risk of receiving unsafe care and treatment.

Supervisors of midwives

- Supervisors of midwives (SOMs) provided 24-hour on-call cover for staff to ensure safe practice. Each SOM was on call at least four times a month. The SOM we spoke with said they were stretched at times, but they were able to fulfil their statutory function. A midwife commented: “We have a strong team of supervisors and they do a good job." We examined the data from the maternity dashboard for November 2013 to October 2014 and noted the ratio of SOMs to midwives was 1:15. This showed the trust had conformed for the last six months to the standard set by the Nursing and Midwifery Council (NMC).

Community midwives

- There were six community teams of five midwives each. We were told the number of midwives per team would soon be increased to six. We were told two community midwives had been on long-term sick leave. There were three regular bank midwives working in the community.
- The community midwives were assisted by six community healthcare workers, who visited mothers and babies to carry out routine postnatal checks that included blood spot screening of newborn babies and helping mothers to breastfeed. They also supported the midwives in the clinics.
- Community midwives took turns to provide on-call cover for home births. They said they had experienced an increased workload and had given their own time to cover the service. A community midwife said: “There are some challenges in providing on-call cover for home births.”
- The community midwives teams were understaffed. This might have exposed women and babies to the risk of receiving unsafe care and treatment.

Medical staffing

- The maternity service employed 16 obstetrics and gynaecology consultants. We were told two more would be joining shortly. There were four medical teams that comprised: consultants; registrars; and junior doctors. Consultant cover was 7 days-a-week, with a consultant on-call out-of-hours. Consultant-led clinics ran daily, and three to four doctors were typically involved in the antenatal clinics.
- According to the maternity dashboard for the period from November 2013 to October 2014 the labour ward consistently had consultant cover for 144 hours per week, which exceeded the target of 96 hours per week.

Handovers

Maternity and gynaecology

- We observed both medical and midwife handovers in the labour ward. They were structured and included discussion of staffing and potential high-risk patients. The handovers showed good team working and respect for confidential information.

Major incident awareness and training

- There was a trust-wide major incident plan, which was reviewed every three years. A copy was posted in each department.

Are maternity and gynaecology services effective?

Good

The maternity service used evidence-based national guidance. Women received appropriate pain relief. The maternity dashboard provided data on patient outcomes.

There was effective MDT working in the maternity department, with other services in the trust and with external organisations. In maternity services staff of all disciplines reported good team support and learning.

Staff development and continuing professional development (CPD) had been encouraged. Midwives felt supported by their line managers and supervisors of midwives. Junior doctors at all levels felt supported by consultants and registrars.

The service provided good support for breast feeding, although the uptake of breast feeding remained under target.

Evidence-based care and treatment

- The trust policies and treatment protocols were based on guidelines issued by the National Institute for Health and Care Excellence (NICE) and the Royal College of Obstetricians and Gynaecologists (RCOG). Staff knew where to find policies and local guidelines, which were available on the trust intranet.
- The trust's integrated governance department issued a risk monthly update in December 2014, which showed that the maternity and gynaecology service was currently participating in two national audits (see below).
- The service was participating in the Health and Social Care Information Centre (HSCIC) National Pregnancy in Diabetes (NPID) audit, and data collection was in progress. The deadline for the submission of data was January 2015.
- The service was participating in Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK (MBRRACE-UK) conducted by the National Perinatal Epidemiology Unit. This data looked at the patterns of intrapartum outcomes. Data collection was in progress, and the deadline for the submission of data is March 2015.

Pain relief

- Mothers reported they had received good pain relief and staff had been responsive to any pain they reported during and after birth.
- Mothers who had epidural for pain relief in labour and women who chose epidural for elective caesarean sections were pleased with their choice.

Nutrition and hydration

- Midwives had provided good support to mothers to breast feed. Support with breast feeding had also been provided in the community by midwives and specially trained community healthcare assistants. The maternity service was accredited by the United Nations Children's Fund (UNICEF) for their Baby Friendly Initiative (BFI). The initiative has adopted internationally-recognised standards of best practice in the care of mothers and babies. It promotes and supports breast feeding, and has recently achieved re-accreditation. The development of the initiative involved establishing policies and guidelines to support the BFI standards, and the provision of an educational programme to enable staff to implement the standards. It required processes to be in place to implement, audit and evaluate the standards. It also stipulates there must be no promotion of breast milk substitutes by the service.
- However, there remained a relatively low uptake of breastfeeding, particularly from 10 days after birth. The maternity dashboard for November 2013 to October 2014 provided data on breastfeeding. The minimum target percentage for mothers to breastfeed shortly after the birth was 95%, but it was generally not achieved. The target was only met in July 2014. The worst month was September 2014 when only 88.7% of mothers breastfed. The average was 91.3%.Breastfeeding by

mothers at 10 days was more successful at meeting a much lower target minimum of 60%. This was met every month except August 2014, when it was 58.5% and averaged 64.4%.

Patient outcomes

- The Q&R monthly update for December 2014 issued by the trust's integrated governance department showed there had been a serious incident in September 2014 that resulted in a patient being transferred from maternity to the ITU.
- Care Quality Commission (CQC) 'intelligent monitoring' system showed that the normal birth delivery rate was 62.3%, which was higher than the England average of 60.5%.
- We examined the maternity dashboard for November 2013 to October 2014. This showed the following data.
- Elective and scheduled caesarean sections were consistently at or below the target maximum of 12% and averaged 10.2%.
- The percentage of emergency or urgent caesareans was always well above the target maximum of 12%, except for September 2014 when it was 10.1%. It reached 17.2% in December 2013 and averaged 14.3%.
- Instrument deliveries averaged 13.7% of all deliveries.
- In four months out of 12 the percentage of failed instrumental deliveries was above the target maximum of 1% at 1.8% in February 2014 and averaged 0.66%.
- Most months the incidence of shoulder dystocia was above the target maximum of three per month, and reached eight for September 2014 with an average of 4.5 per month.
- For seven months the number of cases of meconium aspiration was higher than the target maximum of one per month. For both April 2014 and September 2014 there were four cases.
- For five months the number of term intrauterine deaths and stillbirths exceeded the target maximum of nought per month. Two cases occurred in both November 2013 and August 201, averaging 0.58 per month.

Competent staff

- Junior doctors felt well supported by the consultants. They felt the introduction of a resident consultant out-of-hours on-call system had enhanced their educational opportunities. The in-house training had included postnatal and gynaecology mortality and morbidity audits. There had also been regional teaching sessions once a month. Cardiotocography (CTG) was taught every Monday lunchtime, and gynaecology and oncology teaching sessions were held on Thursdays. An obstetrics and gynaecology student said: "The service is well organised. It is a good place to learn; there is a good case mix."
- Doctors had good relationships with midwives and other staff.
- There were an appropriate number of midwives qualified and experienced in specialist areas, including perinatal mental health, screening and bereavement. The midwifery team was proactive in education and development and provided good planning and support for student midwives.
- We observed an informative staff forum meeting. One topic looked at the use of acupuncture in early labour. At another session the perinatal mental health team talked about how it would like to find midwives interested in learning to provide cognitive behaviour therapy. There was also discussion of the integrated care pathway for perinatal mental health and the associated referral process.
- The midwives confirmed they received statutory and mandatory training annually, and had been given three training days a year. Training had included e-learning and MDT group training.
- Acupuncture training for midwives commenced in November 2014 with an intake of 20.
- Midwives had appraisals, and they felt well supported by line managers and SOMs.
- The SOMs said staff were able to receive appropriate individual support. They provided support through weekly group supervisions, which were also available to student midwives.
- Newly-qualified midwives had preceptorships (practical experience and training) for six months.
- Student midwives said they had good mentorship experience. One student said: "I am very happy with the experience so far. The mentorship is good. I feel well supported." Another student said occasionally they had an agency midwife as their mentor, which was not so good but that this was rare. One student commented: "The training is brilliant. I have been allocated to where I wanted to go to gain experience. I would like to work here when I qualify."
- Students felt supported by the SOMs.

Maternity and gynaecology

Multidisciplinary working

- There was evidence of MDT working in the maternity service, with other services in the trust and with external organisations.
- Clinicians, hospital and community midwives, nursing staff, and medical and midwifery students reported good team support and learning.
- There was good communication between hospital midwives and the community maternity team before and after birth, and with GPs during antenatal care.
- Women with complex health care problems could access other healthcare specialists such as an oncologist or a cardiologist.
- Midwives worked closely with GPs and social care services when dealing with safeguarding concerns or child protection issues.
- There was a regular MDT meeting between the community midwifery service and the family nurse partnership service organised by the Hounslow Council. This bridged the support service between delivery and health visiting support for mothers and babies.
- A senior midwife confirmed the staff had a very good relationship with the midwifery service liaison committee (MSLC), which met with them every three months. MSLC is a voluntary organisation that is made up of people with an interest in developing and improving care in the maternity service. We were told members of the MSLC had been given permission to conduct audits of aspects of care in the postnatal ward and the triage unit, and this had taken place in September 2014. MSLC members told us they were collating their findings and will produce a report in due course.

Seven-day services

- There was consultant cover in the labour ward seven days-a-week, supported by each consultant's team of registrars, senior house officers and junior doctors.
- A resident consultant was on-call out-of-hours for the maternity wards, supported by their team of doctors.
- There was an anaesthetic team available 24-hours, seven days-a-week.
- Pharmacy services were available out-of-hours.
- There was receptionist cover during the day and a member of the HCA team from the antenatal ward provided out-of-hours cover.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- Patients confirmed that their consent had been sought prior to treatment. They described how procedures had been explained to them by both midwives and doctors, and their consent had been obtained before treatment began. We saw patients' signatures in the records we checked.
- Staff confirmed there had been no cases subjected to Deprivation of Liberty Safeguards DoLS). No one was aware of any applications that had been made under DoLS, or any use had been made of independent mental capacity advocates (IMCAs).
- We found that staff had knowledge of the Mental Capacity Act 2005 (MCA) and the DoLS application process. Staff stated they would contact senior practitioners if they had any concerns. They stated they had always asked patients for their consent before carrying out personal care.

Are maternity and gynaecology services caring?

Good

Most women and their partners we spoke with were complimentary about the staff and their caring attitude. However, some expressed disappointment at the service provided, particularly that there were not enough staff available to assist them when they most needed help.

Women were encouraged to discuss their birth plan and choices with their midwife and to be actively involved in planning and decision-making about the birth. We saw good emotional support for women who had had an unplanned caesareanor other complications in labour.

Compassionate care

- The NHS Friends and Family Test (FFT) asks women using each department if they would recommend the service to their friends and family. The results were collated separately for the antenatal, labour service and postnatal services. All the results were poor, with the postnatal service having the worst results. The FFT for the antenatal service was below the England average for six out of 10 months. The labour service FFT figures were below the England average for six out of 10 months.

While the FFT results for the postnatal service were below the England average for eight out of 10 months. The response rate was also well below the England average.

- The CQC survey of women's experiences of maternity services in 2013 provided some feedback. Low scores of 6.6 or less were obtained for: 'were you and/or your partner or a companion left alone by midwives or doctors at a time when it worried you?'; and 'looking back, do you feel that the length of your stay in hospital after the birth was appropriate?'. However, all scores, including these, were generally in line with the England average.
- One mother said: "Generally the doctors and staff were good, but during the evening after my operation I rang the bell three times before a member of staff answered my call. When they came to me they said they had been very busy." The CQC survey showed a score of 7.4 for 'if you used the call button how long did it usually take before you got the help you needed?' compared with the England average of 8.0.
- Mothers and their partners we spoke with were generally complimentary about the service and the care they had received before, during and after the birth of their baby.
- We observed how staff respected people by closing the curtains in the bay and they were observed to ask each person's permission to enter. One person commented: "The staff are very polite, respectful and supportive. I would recommend this hospital to other women."
- One mother, who was recovering from a caesarean operation, said: "It's a good experience. Very kind staff; everyone, including the theatre staff, doctors and midwives. I am very happy with the care."
- The visiting time in the antenatal ward was from 3pm to 8pm, and partners could stay from 8am to 8pm. If the woman was in labour, the partner was able to stay overnight.
- One mother and their partner felt disappointed about the service during her induction of labour in the antenatal ward, and commented: "Although we received good antenatal care and good monitoring, yesterday afternoon we couldn't find a single member of staff when we wanted them. We were told earlier a member of staff would see us in three hours to give the drug, but we waited and waited. Also, it wasn't explained to us what to expect during induction of labour. However, the care itself is good."
- One mother and their partner told us when they arrived in the triage unit they were not seen for 30 minutes because it was busy. They said there was only one band 6 midwife on duty. The partner told us they had to act as an interpreter in labour. The language line was not offered to them. The face-to-face interpreter had not been offered either.
- One woman we spoke with in the antenatal clinic said: "Everyone is nice and kind. Sometimes you have to wait. I understand that."

Patient understanding and involvement

- Mothers confirmed they had been well informed during the antenatal period and before undergoing a caesarean section. They were well informed by the obstetrician and they had seen the anaesthetist, who had explained the options for pain relief, before they signed the consent form.
- One woman said: "I was kept very well informed. I was considered as having a high risk pregnancy. Both the doctors and midwives looked after me very well. I was well monitored throughout my pregnancy and labour. My baby is well too."
- We observed family members and older siblings were allowed to visit during visiting hours. Their presence was respected.
- Mothers we spoke with said they had been involved in decisions about their choice of birth location and the risks and benefits of each. They said they were well supported after their decision. One mother expressed how happy she was with the labour ward team. She said: "All members of the team supported me and my choice of delivery."
- The antenatal clinics had helpful posters on display and information leaflets were readily available.

Emotional support

- Women in labour and in post natal care were allowed to have their partners to stay overnight to give them further support.
- Clinical nurse specialists were available in various disciplines such as screening and to support patients with diabetes. These patients would also be seen in a consultant-led antenatal clinic.
- Women going through a mental health crisis would be seen promptly by the perinatal mental health team, which included a psychologist.

Maternity and gynaecology

- The service had a lead midwife for bereavement counselling, in the event of a stillbirth or sudden death. The MSLC said the team gave very good support for women and their partners going through bereavement.

Are maternity and gynaecology services responsive?

Good

The maternity service had capacity for up to 5,000 births a year. Women were given the choice of a range of options for birth, including a midwife-led natural birth centre, subject to an appropriate risk assessment.

Care was available for vulnerable mothers through specialist midwives for conditions such as diabetes or mental health issues. There was a good bereavement support and counselling service. There was a team of midwives to support teenagers throughout their pregnancy and until two weeks after delivery.

Women attending the antenatal clinics were appropriately booked in and they were seen by a consultant-led team of at least three to four doctors. In the maternity triage unit, women were usually seen within 15 minutes and an assessment was made. Urgent cases such as women with bleeding or reduced foetal movement were prioritised and treated appropriately.

Women attending the EPU were seen by a consultant-led team and urgent cases were prioritised and scanned the same day. However, due to limited capacity scanning for non-urgent cases had to be rescheduled for another day. This was not responsive to the women's need to be scanned without delay.

Women undergoing gynaecology surgery were admitted and cared for in one of the general surgical wards. There had been no delays in their discharges.

The staff employed were of a multi-ethnic mix which represented the local population. The service maintained good communication and relationships with local GPs and other healthcare providers. This ensured that patients received continuity of care when discharged from the hospital.

The maternity bed occupancy between January 2014 and June 2014 was 73.6%, which was above the national average of 58%. In June 2014 the maternity unit was closed to new admissions for four hours because no beds were available.

Service planning and delivery to meet the needs of local people

- The number of births between April 2013 and March 2014 was 4,437. The service had capacity for up to 5,000 births a year.
- The service maintained good communication and relationships with local GPs and other healthcare providers. This had ensured women received continuity of care when discharged from the hospital.

Early pregnancy unit

- The EPU provided a 9am to 4pm service five days-a-week. The EPU had a consultant to support the unit and an on-call registrar to support the junior doctors who covered the gynaecology services.
- The number of women being seen per day was approximately 20, and the unit performed 40 scans a day. The EPU also had sessions on Tuesdays to manage foetal loss, and there was a weekly session for termination of pregnancy that was managed by the gynaecology section of the service. There were referrals from midwives, GPs and community healthcare staff. If a woman was bleeding heavily, frightened or in pain she was admitted to the maternity unit. Urgent cases had therefore been dealt with appropriately.
- However, on 28 November 2014 we found the number of women waiting to be seen exceeded the slots available for the day. We were told 18 women would have to come back another day. Six urgent cases were given appointments for the next day and the rest were told to return in a week when it may be possible to fit them in. This showed women did not always have timely access to diagnosis, care and treatment at a time to suit them. This involved unnecessary travelling and was not responsive to women's needs.

Access and flow

- On arrival in the maternity service women were initially assessed in the maternity triage unit. Urgent cases such as women with bleeding or reduced foetal movement were prioritised. The waiting time was usually 10 to 15 minutes.

Maternity and gynaecology

- The 18-bedded antenatal ward had a rapid turnover of admissions. Women who were unwell and needed to be observed, or who required induction of labour were admitted via the maternity triage unit.
- The antenatal clinics were consultant-led and typically had three to four doctors to see 20 to 30 women, most of whom had been appropriately booked in. The waiting time was short, and when the clinic was overrunning the receptionist informed the patients. The clinics were postcode-based.
- Women with diabetes were seen in the diabetic clinic, which saw around 50 women during the clinic session that usually overran.
- Women had access to the full range of options for birth, subject to an appropriate risk assessment.
- There was a midwife-led natural birth centre for women who had chosen this method of delivery, providing the pregnancy was uncomplicated and had no risk factors such as diabetes. The delivery method, pain relief and further scans were discussed with the woman at 36 weeks gestation.
- At the time of our inspection the two birthing pool delivery rooms had been out of action due to renovation. However, the pool room in the labour ward had been reserved for women who required a birthing pool.
- The maternity bed occupancy between January and June 2014 was 73.6%, which was above the national average of 58%. Occupancy rates above 58% can begin to affect the quality of care given to patients, although we did not observe this.
- In June 2014 the maternity unit was closed to new admissions for four hours because no beds were available.
- We visited the day surgery unit and the surgical ward (Richmond ward) where women undergoing gynaecological surgery shared the same ward as other surgical patients post-operation. There had been no delays in discharges and there was a smooth arrangement for patients who needed to take away medicines.
- Ward management was very tight to ensure beds were available. There was no dedicated gynaecological bay. We were told women for evacuation of retained products of conception (a minor procedure carried out under general anaesthetic to remove pregnancy tissue from the womb) were on fixed lists and usually had two days to wait. We observed that members of staff were visibly dedicated and caring and had a very good attitude towards patients and visitors.

Meeting people's individual needs

- The staff employed were of a multi-ethnic mix that represented the local population.
- Women who attended the antenatal clinic for the first time were given an assessment of needs that included their health and social needs. This identified, for example, their obstetric history or any complications they had experienced in previous pregnancies, or any previous involvement of social services.
- Specialist midwives were available to support women with complex healthcare needs such as diabetes. There was also close liaison with social care services for mothers with learning difficulties or mental health issues.
- There was a perinatal mental health team to provide support for women with mental health issues.
- The service provided bereavement support and counselling through a specialist bereavement counselling midwife.
- The young mums' antenatal group (YMAG) gave support to teenage mothers who were less likely to attend the general antenatal education classes. A team of midwives gave continuity of care from booking to discharge at two weeks postnatal for young mothers. The team booked all teenagers from the boroughs of Hounslow and Richmond on Thames who planned to give birth at the maternity unit.

Learning from complaints and concerns

- We examined the maternity dashboard data from November 2013 to October 2014. The maternity dashboard showed that there had been 13 complaints over the year to October 2014. The month with the most complaints was August 2014, which had four.
- There were leaflets available about how to make a complaint. Women we spoke with knew how to raise concerns or make a complaint.
- Most women we spoke with said they would raise any concerns with the ward staff rather than make a formal written complaint.
- The service responded to comments made on the NHS Choices website.

Maternity and gynaecology

Are maternity and gynaecology services well-led?

Good

The trust was working towards expansion of its maternity service. There were systems in place for clinical governance.

Staff of all disciplines reported the maternity service had a positive, open and supportive culture and staff were complimentary about the management team and the supervisors of midwives, who had ensured safe practice.

The trust was working towards improving the midwives to inpatient ratio, which was 1:36. The ratio of supervisors to midwives had improved and was 1:15. Building work to expand and improve the maternity facilities was in progress, but it was too early to assess its impact.

Vision and strategy for this service

- Staff were aware of the trust's vision to: expand the maternity services; to provide for natural childbirth; to maintain a low rate of caesarean sections; and to provide safe care for women.
- Staff knew the chief executive (CE), the new medical director and the director of nursing and midwifery. Staff confirmed members of the trust board regularly visited the maternity units.
- Staff had been sent daily emails and the CE's bulletin to update them on trust developments. Some staff reported they did not always read them.

Governance, risk management and quality measurement

- The maternity and gynaecology services had systems for clinical governance. There had been three Never Events, two of which involved retained swabs and one which involved a retained tampon. Incidents were reported through Datix, but there seemed to be under reporting of incidents.
- The risk management team had been monitoring all incidents reported on a monthly basis. Risks had been identified and escalated to middle managers. Investigations and reviews had been carried out and the lessons learned had been cascaded down to frontline staff and an action plan implemented to improve the service.
- The consultant-led obstetrics and gynaecology services each conducted clinical audits and held monthly mortality and morbidity meetings. Senior clinicians were visible and approachable.
- There were good clinical care pathways for the care of women in the maternity services, including a very good perinatal mental health pathway.
- One item on the maternity risk register was that the number of midwives was insufficient. The trust was working towards reducing the midwife to inpatient ratio from 1:36 to 1:30. Recruitment was in progress to increase the number of midwives by eight incrementally every year to 2017.
- The ratio of SOMs to midwives had improved since May 2014, and was 1:15 according to the maternity dashboard figures for the year to October 2014.

Leadership of service

- There were clear line management arrangements. Many of the midwives were long-term staff who had worked with the head of midwifery, the matrons and managers. They told us the management team were very visible on the unit and they could approach them about anything.
- The proposed merger with Chelsea and Westminster Hospital NHS Foundation Trust had caused uncertainty, and had resulted in a high number of interim senior and managerial vacancies early in the year. Since then the trust had appointed a permanent director of nursing and midwifery, who started work in recent weeks. Staff said there was a weekly walk around by new members of the board.
- Staff were complimentary about the frontline management team and the supervisors of midwives.

Culture within the service

- The maternity staff of all disciplines reported they worked well together and spoke positively about the service they provided to mothers and babies. However, staff expressed their concerns about the staffing level and skill mix in the maternity services and said they would like to see improvements.
- Staff felt there was a positive, open and supportive culture particularly from managers, who were accessible and supportive of all staff. There was good pastoral care.
- Staff working in the gynaecology service felt over stretched and unsure about the future management of the service. They felt the changes were not sufficiently well explained and that this had created some anxiety for staff.

Maternity and gynaecology

Public and staff engagement

- The trust team actively worked with clinical commissioning groups (CCGs) in commissioning services.
- Mothers and their partners were generally positive about the care and treatment provided. The local MSLC has provided representation for users of the maternity service and other stakeholders. They had had open discussions with hospital staff and felt listened to. They had conducted audits of the services provided and found that generally good quality care was provided. However, they also found that there was limited space in the maternity unit and the maternity triage unit was understaffed.

Innovation, improvement and sustainability

- We noted the trust board scorecard did not sufficiently reflect the data from the monthly maternity dashboard. The only indicators in the scorecard that related to maternity were the percentage of women receiving one-to-one in labour and the percentage of mothers breastfeeding. However the trust told us that a broad range of indicators are reviewed at the monthly Divisional Performance and Finance meeting and then at the Clinical Quality and Risk Committee which is a sub board of trust board.
- In September 2014 the General Medical Council (GMC) education quality assurance team visited the maternity and gynaecology service. Doctors in training had reported examples where they had been undermined by the midwifery team in their clinical management, and that this had been reported using local procedures but without resolution. We were told the GMC visit had led to significant improvements. For example, there had been regular meetings, better interaction and improvements to the rota. We were told the trust's executives had been supportive.

Services for children and young people

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

Information about the service

Children and young people's services at West Middlesex University Hospital NHS Trust are provided on: the special care baby unit (SCBU); the paediatric ward (Starlight); the day unit (Sunshine day unit); a dedicated outpatients department that provides a weekly paediatric urgent referral clinic; and a Hospital 2 Home Nursing team that provides care for children living in Hounslow. The service is part of the Women and Children's Division, and treats 5,000 to 6,000 patients every year. Starlight ward has 20 beds and Sunshine Day Unit eight beds.

The SBCU is located separately to the other services in the Queen Mary maternity unit. It has 16 beds, but this had been reduced to 15 while renovations were in progress. The unit will eventually have 19 cots, six of which will be for transitional care. The SCBU has been assessed as a level 1 unit by the North West London Neonatal Network. This means it can provide care for babies that need additional oxygen and continuous monitoring of their breathing or heart rate. It also has facilities to care for babies that require short term intensive care until they are transferred to a unit assessed to provide that level of care. This is for babies with severe respiratory disease or who require surgery.

We visited the inpatient and outpatient areas, the A&E department and the theatres recovery area. We talked to 12 children, 20 parents and 35 staff including: nurses; doctors; play specialists; and support staff. We also observed the care and treatment being delivered.

Summary of findings

We found many aspects of the service were good, but some areas required improvement. They included infection prevention and control (IPC), feedback and learning from incidents.

There were good arrangements for safeguarding children and babies and staff were aware of their responsibilities. Children and young people were cared for by staff who had received specialist training. There was consultant cover seven days-a-week, and the trust was recruiting additional consultants.

Staff used evidence-based guidelines, audits and peer reviews. But, feedback and learning from incidents and compliance with hand washing guidelines, particularly on the SCBU, needed to be improved.

Children and parents we spoke with were positive about staff and the care they received.

They felt staff involved them in discussions and decisions about their care. On the children's ward formal feedback was sought from parents and children, but this was not happening on the SCBU.

Leadership in children's services was good, but changes and a lack of effective leadership on the SCBU had impacted on staff and the mechanisms to monitor the quality of care. This was an area that needed improvement.

Services for children and young people

Are services for children and young people safe?

Requires improvement

We found the services for children and young people were safe, but some aspects such as Infection Prevention and Control and feedback and learning from incidents required improvement.

At the time of the inspection the SCBU was undergoing a refurbishment to increase the number of cots. This had made it difficult to store equipment. The corridors were cluttered with a range of equipment including baby baths, an ophthalmoscope machine for eye examinations and linen bags. They took up more than half the width of the corridor and partially blocked access to the safety exits. We found a layer of dust on two incubators and medical staff did not always wash their hands on entering the ward or SCBU.

Although staff reported incidents and were able to give examples of some changes following incidents, feedback and opportunities to learn from incidents needed improvement. Some improvements had begun to take place. For example, we found that the IT reporting system was being amended to include feedback to staff.

Safeguarding policies and procedures and named staff were in place, and staff were aware of them. Medical records we reviewed were up-to-date, and relevant sections of the medicine administration charts we reviewed had been completed.

Incidents

- All incidents were reported through a centralised IT system, and, although staff reported incidents, senior staff were aware that there was room for improvement in providing feedback to staff.
- Staff in both the SCBU and paediatric areas did report incidents. They were able to give examples of events that would trigger an incident report such as medicine error, a baby admitted from the community, an unexpected admission to the SCBU and staffing issues.
- The trust board minutes demonstrated that serious incidents were investigated along with lessons learnt.
- Some senior staff felt that there was still some under-reporting of incidents. Staff acknowledged that if the incident wasn't reported immediately it may not be reported at all.
- Examples of changes following incident reporting were limited. SCBU staff were able to describe changes made after incidents related to the administration of antibiotics to babies on the postnatal ward.
- Staff on the SCBU and children's ward told us they did not always receive feedback about either individual incidents or themes from incidents. Some action has been taken to address such as amending the IT system to include a request for feedback.
- Mortality and morbidity meetings took place monthly, and were attended by staff from both children's ward and the SCBU. Staff on the SCBU told us they attended if they had time. Information showed that out of the last three meetings one member of staff had attended one meeting.

Cleanliness, infection control and hygiene

- The majority of staff (94.4%) in the Women and Children's Division had completed infection prevention and control training in July 2014.Staff were aware that weekly hand washing audits took place but were not aware of the results.
- The children's areas, not including the SBCU, achieved 100% compliance for hand washing and decontamination of medical devices between April to October 2014.For the same period the SCBU achieved 100% compliance with hand hygiene.However, on three separate occasions we observed that medical staff did not wash their hands when they entered the SCBU or children's wards.
- Compliance for decontamination of medical devices was variable at between 40% and 100%.
- In June and August they had achieved 50%, but in October it was 40%. The latest results were displayed at the entrance to the SCBU.There was no reference to the compliance outcomes in the minutes of SCBU staff meetings on the SCBU. Staff were unaware that any action was required in response to the decontamination of medical devices findings. Senior staff told us that this should have been picked up by the quality and risk meetings.
- Equipment on the children's wards was clean and green stickers were used to indicate what was clean.However, an incubator in the SCBU set up ready for use was

covered by a thin film of dust, although protected by a plastic sheet. An incubator in the corridor also had a thin film of dust on the outside. The area around the blood gas machine had dirty trays and trays with sharps and blood stained swabs. We were informed by the nurse in charge that this was an ongoing problem and that the machine was used by staff from the maternity wards. The issue had been raised with senior staff in other departments, but it had not resulted in any improvement.

- Stethoscopes on the SCBU were not located at each neonatal cot, and the same stethoscope used for several babies, which increases the risk of infection. This was raised with the staff in charge of the unit, who were clear that the same stethoscope should not be used for several babies.
- MRSA swabs were taken from babies when they were admitted to the SCBU.

Environment and equipment

- Access to the SCBU and children's wards was secure either via a swipe card or entry phone.The department had a range of equipment that was checked and sent for regular maintenance. However, we did find examples where some equipment had not been checked.The resuscitation trolley on the SCBU had not been checked in line with the local network policy, which states that it should be checked weekly. According to the records dated 26 November 2014 the trolley had not been checked since 15 November 2014.
- One SCBU nurse had dedicated responsibility for checking and maintaining the monitors, incubators and ventilator, and a healthcare assistant was responsible for cleaning all other equipment.
- The equipment on the children's ward was clean.Staff in the SCBU had to demonstrate their competency in using equipment and records demonstrated this had been completed.
- SCBU staff reported difficulties in the timely removal of full clinical waste bins and linen bags. On the first day of the inspection they were full by mid-morning and staff were unsure when they would be removed and replaced.
- The SCBU had a dedicated parents' room with a separate room for women who wanted to express milk. Tea and coffee facilities were available. There was a four-bed area opposite the SCBU for women to stay overnight prior to the discharge of their baby.While younger children did not have single sex provision, teenagers did.The children's ward had a separate sitting room for adolescents with play stations and a range of DVDs, games and books.There was an activity area for younger children with age-specific toys.
- There were three dedicated recovery beds for children in theatres in a bay separated from the adults' bays.A&E had a dedicated area for children, but it was not separate to the area for adults and it could be used as a thoroughfare because it led to the exits.

Medicines

- Medicines were stored safely and securely on the children's wards and the SCBU. Medicines were stored and locked in line with legal requirements. SCBU staff told us that controlled drugs were checked twice daily and were able to show us a record of checks by two staff.
- Fridge temperatures were checked and recorded daily to ensure medicines were stored in line with manufacturers' recommendations.We reviewed six medicine charts on the SCBU unit and found that all the relevant sections had been completed. This included the allergies section, gestational age and doses were appropriate. Antibiotic prescribing was also in line with national guidance, and gentamicin (an antibiotic used in bacterial infections) levels were checked and where appropriate doses were modified.

Records

- Medical records on both the SCBU and children's ward were kept in a trolley next to the nurses' station.We reviewed several care records on the children's wards. They were up–to-date and contained specialist records for safeguarding and communication with children.Care plans on the SCBU were pre-printed. We did not see any evidence that they had been adopted to meet individual patient and family needs. However, the five SCBU medical records we reviewed showed evidence of consultant-delivered care, and that social concerns were being recorded.

Safeguarding

- The hospital had named staff for safeguarding children. The trust had developed the Local Safeguarding and Promoting the Welfare of Children and Young people - Policy and Procedures (2013), due for review in 2016.

Named staff included a midwife in the Women and Children's Directorate and a paediatric consultant. Staff were aware of the nominated individuals and how to report concerns.

- Children attending A&E were cross-checked twice against the child protection registers for the three main boroughs covered by the hospital.The safeguarding lead nurse carried out daily checks of any admissions to A&E and attended handover meetings in paediatric inpatients.
- In July 2014 the Women and Children's Directorate had exceeded their target that 80% of staff should complete Level 3 training. In November 2014, 71% of SCBU staff had completed Level 3 training. This was because some staff had been on maternity leave. On the children's ward 69.7% of staff had completed Level 3 training and 93.55% of medical staff. The home care nursing team were 100% compliant with Level 3 training.
- Staff on the SCBU attended a fortnightly meeting ('psycho-social meeting') with social services staff to review babies at risk. In between these meetings they told us they raised any concerns with the named midwife.Nursing staff in outpatients told us they would document and inform the paediatric medical staff if they noticed any bruising on a child, and they were aware of the named safeguarding staff.Staff were able to give us examples of when they had raised concerns using the safeguarding procedures.

Assessing and responding to patient risk

- The children's ward used the Paediatric Early Warning System (PEWS) and the forms were regularly audited.A&E did not use an early warning score system but did record observations of children. During our inspection we had to alert staff to an alarm that was indicating a possible deterioration in a child's condition.
- Babies on the SCBU who required intensive care were transferred out to a hospital in the neonatal network area.The charts we reviewed on the SCBU and children's ward showed that observations had been recorded in the appropriate time frames.

Nursing staffing

- In August 2014 the trust had an overall vacancy level of 7.13%. The Women and Children's Division had a vacancy level of 3.5%.The children's ward had 33.67 full-time staff, which was over its establishment of 31.24 full-time staff. Staff worked 12-hour shifts, and there were four nurses on duty each shift that increased to five in the winter months to accommodate increased admissions. Although over the trust-determined establishment, in a recent staffing levels review the matron found that they did not meet the recommendations for children's inpatients in the Royal College of Nursing guidance Defining staffing levels for children and young people's services (2013). This had been highlighted as a risk and was placed on the risk register with discussions planned for December 2014 with the Director of Nursing and Midwifery.
- The SCBU was understaffed by approximately two full-time nursing staff, but the unit was planning to recruit staff to cover the additional beds that were being created.The band eight post in the SCBU was vacant, and one of the band seven nurses was acting up until the post had been filled. They were not included in the staffing level numbers.Paediatric outpatients was staffed by two support workers with oversight by the nurse in the children's day unit. Although assistance was available, we were told by support staff they would appreciate a more visible presence.

Medical staffing

- Of the doctors working in children and young people's services 70% were registrars, compared with the England average of 51%. The figure for junior doctors was 9% of compared with the England average of 7%. At 21% the department had fewer consultants than the England average of 34%.
- There were nine paediatric consultants in post. From April 2014, the establishment had been increased by 2.9 full-time staff to 10.3 full-time staff. The 0.3 had been filled and the trust was currently recruiting for the remaining 2.6 full-time staff.
- In 2014 the trust agreed with the commissioners to split the rota for general paediatrics and neonates to improve support, and there are now dedicated sessions for neonates.Three consultants provide weekly cover for the SCBU with a designated consultant for paediatrics. One consultant was onsite over the weekend until approximately 4pm each day together with two junior doctors (FY 1-2), who covered the wards. After 4pm consultants were available via telephone.The trust aims to provide 14 hours consultant weekend on-site cover each day by 2017/18.

Services for children and young people

- Daily ward rounds took place on the SCBU and paediatric inpatients. We observed a morning medical handover that covered a range of issues including: safeguarding concerns; care planning; chasing missing test results; and serious incidents.

Major incident awareness and training

- The trust has a major incident plan that had been reviewed in October 2014, and a Business Continuity Management Strategy approved in May 2014. Staff were able to locate the current major incident plan, and senior staff were aware of the plan and able to explain their role and responsibilities in the event of a major incident.

Mandatory training

- All staff in children and young people's services were working towards completing their mandatory training.By 27 November 2014, 91.3% SCBU staff had completed fire training against the target of 95% of staff. On the children's inpatients ward the figure was 94.12% together with 80.56% of medical staff.The target new born and paediatric life support training is 80%. Half (50%) of medical staff had attended new born life support and 63% paediatric life support training.
- SCBU nursing staff had achieved 80% compliance with new born life support training. On the children's ward 76.47% of nursing staff had attended paediatric life support training against a target of 80%. All staff working in the paediatric recovery area had completed life support training.
- Medical staff compliance with training on the patient experience (positive and respectful culture) was low at 5.56% against the 80% target - two out 36 staff had completed the training. But, 84% had completed training in consent, which was higher than the 80% target.

Are services for children and young people effective?

Requires improvement

Children and babies received effective care, but some areas could be improved. We found that staff used a range of evidence-based guidelines. Clinical audits were taking place and although staff on the children's ward received feedback, this needed to be improved on the SCBU. Staff on the children's ward used specific tools to assess pain, but this did not happen on the SCBU.

Staff had had appraisals and meetings took place on the children's ward and on the SCBU, but a number of different forms were in use in the SCBU.

There was a multidisciplinary approach to care that was more formalised in children's services. On the SCBU multidisciplinary working happened, but it was less formal.

The SCBU did not use a pain scoring tool to assess if babies were experiencing pain.

There was seven-day consultant cover, and all staff on the children's inpatients ward had received specialist training in caring for children. On the SCBU each shift had staff trained in how to care for new born babies.

Evidence-based care and treatment

- Children and young people's services used the National Institute for Health and Care Excellence (NICE) guidance, and guidelines from the Royal College of Paediatrics and Child Health and the North West London Neonatal Network.
- Guidelines were available on the intranet. We reviewed the surfactant policy (a substance given to new-born infants who may have immature lungs and lack this substance, and need support to help prevent respiratory distress and subsequent mortality) and neonatal antibiotic prescribing was evidence-based and referenced NICE guidance. The neonatal antibiotic guidance was being reviewed and updated to incorporate current NICE guidance (Antibiotics for neonatal infection QS75: December 2014).

Pain relief

- The SCBU did not use a pain scoring tool to assess if babies were experiencing pain. But, we were told that oral sucrose was used to reduce any pain they may experience.On the children's ward staff assessed children's pain using a range of tools, one of which was the FLACCs (face, legs, activity, crying and comfort) tool. The tools included a range of pain relief options and staff had contact details for the pain team. A review of notes showed that staff were using the tools.A play specialist was also available to assist and distract children as required.

Services for children and young people

Nutrition and hydration

- A range of food and snacks were available for children as required, and on request there were foods that met different faith requirements.Breast feeding mothers and pregnant women were provided with meals while their child or new born baby (if they were rooming in) was in hospital.Support was available for mothers with babies on the SCBU to express milk in a private area.Formula milk and pureed food baby food was available, and parents could bring in their own baby food.For children admitted late in the evening a snack box was available.

Patient outcomes

- The trust was not an outlier (patients on wards that are not the correct speciality for their needs) for paediatric and congenital disorders.Information from the Integrated Governance team showed that between April and August 2014 the service had determined to conduct three audits: cranial ultrasounds on premature babies; vitamin D testing on children on antiepileptics; and children with petechial rash (NICE guidelines, CG102). The audits were at the data collection stage.
- Children and young people's services participated in the National Paediatrics Diabetes Audit 2011/2012 (December 2013), and also had a multidisciplinary peer review visit in December 2013 (July 2014).
- The National Paediatrics Diabetes Audit examines the quality of care and outcomes in children and young people with diabetes. The 2011/2012 audit found their results for HbA1c were in line with the England average (HbA1c is a marker of blood glucose levels over eight weeks that is an indicator of the effectiveness of treatment - a high level indicates a poor control of blood glucose levels).
- The peer review visit in December 2013 found that all the core members of the paediatric diabetes team were "committed and patient-focused", but resources were limited. The team had only one consultant, who was providing on-call cover 24-hours-a-day throughout the year, except when out of the country on leave, and one specialist nurse with a part-time dietitian.The peer review found a lack of general administrative support for the paediatric diabetes team.
- Guidelines were available and there was good documentation of patient assessments. They had recently introduced text reminders for appointments, which had reduced the non-attendance rate from 20% to 6%. Following the peer review visit the number of consultants had been increased to two, together with dietician support. There is still a lack of administrative support, which means they are not recording best practice tariff data.
- Other changes following audits include the introduction of a checklist to ensure all actions were taken following a safeguarding audit that found some gaps in safeguarding documentation.
- Audits were an agenda item at the women and children's quality and risk meeting. However, for the September, October and November 2014 meetings the item was either "carried forward" or "no further progress" documented.
- Nursing staff on the children's ward told us that local audits, such as hand washing, documentation for pain assessment and medicine charts, took place and they received feedback on the outcomes.
- We saw no evidence of regular audits on the SCBU. SCBU staff were unable to tell us the outcome or any changes as a result of the IPC audit or other audits. We were given the details of a March 2011 audit on the management of nasogastric/oral gastric tube (a tube passed into the stomach via the nose or mouth to provide short/medium term nutritional support or aspiration of stomach contents).
- The service has a higher readmission rate (within two days of discharge) for non-elective ear nose and throat admissions compared with the England average.

Competent staff

- Junior medical staff reported they felt supported by the consultant team in their response to the General Medical Council national training survey.
- By July 2014 80% of staff in the Women's and Children's Directorate had had an appraisal in the last 12 months. Some staff said they found the appraisal process helpful, but in the SCBU we found a number of different forms in use and some had not been signed by staff.
- All nursing staff on the children's ward had received paediatric training, and on the SCBU they had four nurses on each shift with a minimum of two staff who had completed the specialist training course in neonatal care. One support worker had been supported financially to undertake her general nurse training and was now being supported to undertake specialist neonatal care training.

Services for children and young people

- Staff working in other areas of the hospital where children are treated, such as A&E, had all completed life support training and always had paediatric-trained staff on each shift. They were also included in the paediatric training programme.

Multidisciplinary working

- Multidisciplinary (MDT) working was taking place, but not formalised on the SCBU.SCBU nurses attended MDT meetings to discuss safeguarding concerns, but did not have MDT meetings on the unit. However, they did liaise with other staff including doctors, dieticians and midwifes.
- Discharge planning and diabetes care for children was multidisciplinary. We observed a discharge planning meeting that included doctors, physiotherapist and staff from the children's ward and SCBU. The meeting demonstrated that staff had an understanding and were responsive to the needs of children and their families.
- There were arrangements to transfer babies and children that needed intensive care at other local hospitals.Children who attended A&E and required mental health support could be admitted to the children's ward or transferred to the child and adolescent mental health service. Where appropriate support from a mental health trained nurse was arranged.Overall staff reported good team working.

Seven-day services

- There was seven-day consultant cover for the children's ward and the SCBU. The trust was working towards increasing the hours of consultant cover by 2017/2018.

Access to information

- Staff could access guidelines via the intranet and e-learning to complete their mandatory training.Information for parents was also available.Arrangements were made for parents to be present during ward rounds.

Consent

- Staff on the paediatric ward explained how consent was obtained. They involved both the child and the person with parental responsibility and explained that it was an ongoing process.SCBU staff told us that they mainly sought verbal consent for procedures such as a blood transfusion.We observed staff in the paediatric day surgery following good practice guidance when obtaining consent.

Are services for children and young people caring?

Good

Parents and children were positive about the staff and the care they received. They felt staff were approachable and provided clear information. We observed staff involving parents in discussions about their children's care.

Feedback from parents on the children's ward was sought using the Family and Friends Test (FFT), which was due to be officially launched in 2015. The SCBU had its own feedback form, but this had not been used for several months.

Compassionate care

- Formal feedback from parents with babies in the SCBU was limited. The SCBU had patient feedback forms, but they had not been used for several months.The FFT does not go live until April 2015, but the children's ward had started giving out the forms.During the inspection we saw parents and children were treated with compassion and dignity.
- We spoke with 10 parents and their children in the children outpatients department, and all said they found the nurses and doctors friendly and caring.Parents said they found the staff "pleasant and helpful", and one child said "the people are very nice. When I was having my blood test done they did it quickly and nicely".On the children's ward parents told us they were happy with the care their children received and that staff engaged with the children and "entertained" them.Parents on the SCBU told us that the medical staff visited them and they were able to visit the unit prior to delivery. Medical staff were described as "amazing" by one mother because they had returned to the antenatal ward to repeat the information to her partner because he had not been present when they had made the initial visit.On one occasion we observed that when a father became distressed during a ward round and no one had comforted him or offered him a tissue. Other parents in the SCBU told us the staff were supportive and friendly.

Patient understanding and involvement

- We observed doctors explaining to parents why their baby had been admitted to the SCBU and the treatment

plan.Staff on the children's ward told us that children were involved in discussions about their care, and a parent told us how their child's discharge plan was adapted to take into account the needs of the family.Parents told us staff were approachable and they received "clear information" from doctors.

Emotional support

- Parents could access support from the multi-faith service that provided a seven-day service.Parents with sick babies on the SCBU could talk to the bereavement support midwife. They had a process that involved giving parents time to spend with their baby and putting together a Memory Box for them.
- For children and young people receiving end of life care we were told that a care plan would be developed with all the relevant agencies that included the continuing care team. Children could be cared for at home, the local hospital or the hospital.

Are services for children and young people responsive?

Good

Many aspects of the service were responsive to the needs of children and young people. Examples of how the service responded to the different medical needs included the Hospital to Home Nursing Team and the urgent referral clinic. The number of cots on the SCBU was being increased to accommodate the planned increase in the number of deliveries in maternity.

Open visiting was in place for parents together with arrangements for them to stay overnight. The individual needs of children were accommodated by dedicated areas (not beds) for different age groups and different activities.

Information about complaints showed that there was a range of methods to try and resolve issues that included local resolution meetings. The outcome and learning from complaints was recorded.

Service planning and delivery to meet the needs of local people

- Parents and children were able to access the service through their GP and A&E.The Hospital to Home Nursing Team provided care for children in their home, reducing the need for them to attend or be admitted to hospital. They carried out a range of services from taking blood to dressing wounds. The team consists of four band six nurses, three of whom worked part-time. Where possible the service is flexible and visits children before or after school to minimise disruption to their day. They do not provide an oncology service. However, they will visit children who are under the care of consultants in other hospitals, but who live in a local borough.
- The number of cots in the SCBU was being increased to accommodate the planned increase in the number of deliveries. There would be a further two cots with six for transitional care.The SCBU was part of the North West London Neonatal network and worked closely with other hospitals to transfer and receive children.The SCBU could accommodate up to two babies that needed high dependency care for a short period of time.

Access and flow

- Information about the occupancy rate for the SCBU was provided as a number of babies admitted to the unit rather than as a percentage. Between April and October 2014 the number of babies admitted to the SCBU each month ranged from 33 to 45.A range of outpatients clinics were available, but some were overbooked and ran late such as the ear nose and throat clinic (ENT).
- To minimise the delay we were told that consultants came in early to start clinics.Some parents we spoke with told us about delays they experienced in the children's outpatients department. Delays ranged from 20 minutes to two hours.
- There was a weekly urgent referral clinic for children and a dedicated blood test (phlebotomy) service.When the children's ward experienced busy periods it could result in delays in children being admitted from A&E. This meant that on some occasions because of the lack of beds children had to be cared for overnight in A&E. On other occasions the playroom was used to accommodate children until a bed became available.

Meeting people's individual needs

- Interpreter services were available via the phone or in person for children and families for whom English was not their first language.A range of information leaflets in English only were available. We were told that information could be translated into other languages if required.
- The SCBU and children's ward had open visiting for parents or those with parental responsibility. For other visitors on the children's ward it was from 1pm to 8pm,

and on the SCBU between 3pm and 8pm and limited to two people.During the winter months siblings were unable to visit the SCBU to minimise the risk of infection to babies.

- On the children's ward the play specialist and the teacher provided activities for children and helped them keep up with their school work. There was a fully stocked play room with toys.There was a separate lounge for teenagers that had a range of books, DVDs and games.
- Mothers with babies on the SCBU could 'room in' and were provided with meals. There was also a separate lounge for parents on the SCBU with tea and coffee facilities, and a separate area for breast feeding.On the children's ward parents could stay overnight on a fold out bed next to their child's bed.Mobile phones could be used, but had to be switched off or turned to silent after 8pm.

Learning from complaints and concerns

- Information was available about the Patient Liaison and Advice Service (PALS) on both the SCBU and children's ward, but there was no information about how to make a complaint.Staff on the SCBU told us they were unaware of any complaints about the unit. Staff on the children's ward told us they tried to resolve issues as they arose, and escalated them to the nurse in charge or manager if necessary.
- Information provided by the trust showed that between August 2013 and August 2014 eight or ten (unclear from data) complaints were received about services for children and young people. None of the complaints related to the SCBU. The information contained a short summary about the complaint and the action taken, which included lessons shared with staff.Three of the complaints were about care and treatment, while the others concerned communication, attitude and lack of sensitivity. Seven of the complaints were upheld, and one was resolved while the child was still on the ward.

Are services for children and young people well-led?

Requires improvement

The quality of leadership varied across the service. Leadership in children's services that included the ward and day unit was stronger than in the SCBU. Staff were providing good care, but changes and a lack of effective nursing leadership had impacted on SCBU staff. This was demonstrated when staff were unable to provide documentary evidence of how they assured themselves about the quality of care provided on an ongoing basis. Although the children's ward matron provided support and tried to be visible, more management support and leadership was needed for SCBU staff. There were systems for clinical governance, but some aspects needed to be strengthened.

Vision and strategy for this service

- The main area of development for the service was the increase in the number of cots in the SCBU.The increase was part of the shaping a healthier future programme that would generate growth in the maternity and paediatric workload.SCBU staff were aware of the plans to increase the number of cots and staff.

Governance, risk management and quality measurement

- The monthly quality and risk meeting was the key governance meeting for the division. Audits in progress focused on national audits, and future audit plans included discussions with parents or people with parental responsibility.Senior staff were aware that although staff were reporting incidents and they were being investigated, incident reporting was an area that required further work such as feedback to staff.
- Incidents were discussed at the women and children's quality and risk committee, but for two of the last three months paediatrics had not provided a report. However, some issues including access to GP referral letters in clinics were discussed. Medicine incidents are reported separately to the group. We were told that information from medicine incidents was shared with staff via email.
- Some staff were aware of the divisional risk register, but others were not and did not know how to access it. There was a general lack of appreciation of the use of risk registers and staff highlighted some issues that although identified as a risk had "fallen by the wayside".
- Arrangements for safeguarding children were well developed and staff were aware of the procedures and their responsibilities.On the children's ward information was fed back to staff at the monthly staff meetings.

- SCBU staff had monthly team meetings until June 2014, but there was little evidence of discussion of incidents, feedback from patients or actions following audits. The meetings were more operationally focused.

Leadership of service

- There were line management arrangements, and staff were aware of who their immediate line manager was, although some SCBU staff were unsure if they were overseen by maternity services or children and young people's services.
- The leadership in children inpatients was good, but staff in the outpatients department told us they would have appreciated more structured support. Although a named registered nurse on the children's ward provided daily oversight this was not monitored to assess how effective the arrangement was.
- On the SCBU a band seven nurse was acting up to the band eight role with support from the matron in children's services. The previous band eight had been in post for less than a year, whereas the nurse prior to that had been in post for many years. At the time of the inspection the post had not been advertised, but following the inspection recruitment plans are now in place. The impact of no effective leadership was reflected in the lack of formal mechanisms to demonstrate the quality of care staff were providing.
- Although staff were providing good care, they were unable to provide recent documentary evidence to support this. For example, when we asked about audits we were given one dated 2011, and there was no information about action following findings from the recent decontamination of equipment audit.
- One of the consultants was the designated medical lead for the SCBU. They had reviewed consultant cover on the SCBU to strengthen and improve continuity of care. As a result there were now three consultants to provide cover on weekly basis.
- We were told informal discussions took place between the nurse in charge and the lead consultant/consultant in charge for the week, but there was no record of issues discussed or changes made as a result of these discussions.Senior managers told us they were proud of the changes that have taken place in children's services and felt that the roll out of the PEWS had gone smoothly.

Culture within the service

- Staff we met during the inspection were open and friendly and reported good team working, although multidisciplinary working on the SCBU could be more formalised.The lack of a visible and effective leadership and robust governance structures at a local level on the SCBU meant that staff were not motivated to look for ways to continue to enhance and improve the standard of care provided.
- In the SCBU there was a sense of resignation to some of the ongoing problems because although staff had raised issues, no action had been taken to resolve them. Examples of this included the ongoing problem in maintaining the cleanliness of the area around the blood gas machine.

Public and staff engagement

- Feedback mechanisms for children and parents varied.The children's ward used the FFT - Friends and Family Test. They also took part in the "You Said we did!" initiative where children and parents raised issues, and the changes/responses were publicised on information boards on the children's ward and outpatients department.Formal feedback mechanisms on the SCBU were limited. The FFT had not been rolled out, and although they had their own feedback form these had not been given out for parents to complete.

Innovation, improvement and sustainability

- Improvements to the SCBU were focused on the extension of services.
- Although there were examples of clinical audit and some improvement activity, we did not find a coherent joined up vision of a quality improvement plan.

End of life care

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

Information about the service

Palliative care services at West Middlesex University Hospital NHS Trust are led by a visiting consultant specialist from the Ealing and Hounslow Specialist Palliative Care Service. The consultant, who is not directly employed by the trust, has two sessions a week at the hospital and is supported by two clinical nurse specialists (CNS), who provide services from Monday to Friday. The palliative care specialists have good joint working with the chaplaincy, hospital pharmacist, physiotherapists, occupational health and social worker.

The trust reported 741 patient deaths from April 2013 to March 2014, and during this period the palliative care specialists received 336 referrals. The specialists accept referrals for any adult who needs palliative care, and not all are necessarily cancer patients. Referrals were routinely received from any of the trust's wards, and from community teams that include community specialist palliative care teams, district nurses and GPs. The hospital palliative care specialists also provide telephone advice and signposting for community teams that only require advice.

We visited medical, surgical and care of the elderly wards, and considered the care given to patients at the end of their lives in specialist areas such as A&E, critical care unit (CCU) and high dependency unit (HDU). We spoke with relatives and staff, which included the executive lead, visiting consultant, CNS and ward staff. We were unable to speak to any patients receiving end of life care because they were too ill to be interviewed. We looked at patient medical and point-of-care records. We met the chaplains and the mortuary staff, and were shown the resources and facilities available to them.

End of life care

Summary of findings

We were impressed by a small palliative care team operating with great dedication and to the best of their ability in a seriously under-resourced function within the trust.

The specialist palliative care services at West Middlesex University Hospital NHS Trust were considerably smaller than most hospitals of an equivalent size. National commissioning guidance recommends that per 250 hospital beds there should be a minimum of one whole time equivalent (WTE) consultant and one WTE CNS to provide clinical services, excluding education and training. West Middlesex has around 400 beds, and should have 1.2 WTE consultant and 1.6 WTE CNS input. However, the hospital had one-sixth of the required specialist palliative care consultant and 2.0 WTE CNS.

There was no formal CNS cover for absences. Out-of-hours cover for the consultant was provided by the team at Meadow House Hospice. Phone calls went to nursing staff in the first instance, and calls could be referred to a consultant if necessary. We were told that it was normal to deal with these enquiries on the phone, and it was rare for the consultant to decide to visit the hospital. The hospital had very recently employed a second CNS to provide support to the existing nurse specialist. However, we were not told of any plans to increase consultant support.

There was no trust End of Life Care (EoLC) policy or strategy. Staff reported there had been very little consistent senior management engagement, although the palliative care specialists felt the deputy director of nursing was engaged with their challenges and future goals. They were unsure of who led on EoLC at trust board level. However, the medical director had recently been told that they had responsibility for EoLC at board level. The director spoke positively of plans to increase the profile of EoLC by re-invigorating and re-engaging hospital staff at all levels.

The palliative care specialists, chaplaincy and nursing and trust lead spoke about their future aspirations to bring patients' EoLC to the forefront of staff minds through training. They explained that they wanted to develop integrated care pathways that involved community services such as GPs and nursing homes. However, the palliative care specialists had little time to develop this or provide staff training because their working day only allowed time for clinical support.

Most hospital staff were complimentary about the support they received from the existing specialists. Junior doctors particularly appreciated their support and advice, and said they could access the CNS help via a bleep system at any time during the day. They recognised that the CNS and visiting consultant were very hard working. The specialists did not have the resources to provide support to patients seven days-a-week. Ward staff knew how to access palliative care advice or consultant support out-of-hours. The specialists usually responded within 24 hours.

The specialists were passionate, caring and maintained patients' dignity throughout their care. Where the specialists had been involved in patients' EoLC we saw appropriate recognition that the patient was dying. We saw that escalation procedures, discussions and advice were documented in detail. However, we found there was a mixed response to how patients reaching the end of their life were cared for by ward staff. Staff did not always recognise patients were in the end stages of dying, and therefore escalation and appropriate support was not always given in a timely manner.

We found when the specialist palliative care CNS was brought in to help manage a dying patient that procedures had been correctly followed, and the patient and relatives had received a good level of care. However, this was entirely dependent on the involvement of the CNS at an early stage. There were weekly specialist palliative care multidisciplinary (MDT) meetings, but meeting notes showed that these had only taken place on 30 out of the 52 weeks throughout the year.

The trust had developed end of life guidance called the compassionate care agreement, which replaced the Liverpool Care Pathway. This had been piloted; had now been in place for two months and was due to be audited on its implementation in January 2015. A majority of the do not attempt cardio-pulmonary resuscitation (DNA CPR) forms we reviewed had been completed in full and appropriately. Documentation of mental capacity assessments was also inconsistent. There were limited

End of life care

governance systems, although some audits had taken place. It was not known how accurate the data for the palliative care specialists' annual report was because data collection systems were not robust. The CNS believed that they were involved in between 50 and under100 deaths per year on the wards. There was no system to identify dying patients who were not already under the CNS. Therefore, we concluded that patients and families were not benefitting from specialist palliative care input and support as they should.

There were no dedicated specialist palliative care beds at the hospital, although staff would try to care for people at the end of their life in a side room to ensure privacy. There were no visiting restrictions for visiting family and friends. The palliative care specialists were able to arrange rapid discharge for people who wished to die somewhere else such as at home or in a hospice.

We found the care and support given to relatives after the death of a family member by the mortuary staff and patient affairs office to be exemplary. The chaplaincy had a good working relationship with the palliative care specialists, and provided emotional and spiritual support to patients, relatives, friends and staff.

Are end of life care services safe?

Requires improvement

We found the palliative care specialists were significantly under-resourced and as a result were unable to provide an acceptable level of end of life care to many patients or to pass the cancer peer review standards.

The specialist palliative care services were provided by two clinical nurse specialists (CNSs) during working hours, Monday to Friday, and a consultant for two sessions a week. In the first session the consultant visited patients on the wards, and in the second attended MDT meetings. There was no cover in the hospital for the CNSs when absent, for example during annual leave. An on-call consultant service was available to provide out-of-hours support by contacting the ward nursing staff at Meadow House hospice, who could refer on to an on-call consultant as necessary.

End of life care was not included in the trust's mandatory training programme. The palliative care specialists had an increasing work load, and although they had recently employed another clinical nurse specialist they were only able to support an already busy service. There were no plans to increase the consultant cover from two sessions per week to the national standard for a trust of its size. There were no link nurses on the wards to support the delivery of care.

The trust had developed end of life guidance called the compassionate care agreement (CCA) to replace the Liverpool Care Pathway. It had been running for six months and was due for audit on its success in January 2015.

Most patients' families told us their relative's pain was controlled well and anticipatory medication was prescribed and available when needed. The hospital was in the process of changing from Graseby syringe drivers to McKinley T34 syringe pump drivers in accordance with the 2011 National Patient Safety Agency (the former NPSA) safety alert.

Where palliative care specialists were involved in providing care, patient records and escalation procedures were clearly documented. However, staff recognition of a dying patient and the support they required varied across wards.

End of life care

Incidents

- There were no Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) or serious incidents reported.
- All staff we spoke to were knowledgeable about incident reporting processes.
- Mortuary staff had access to Datix (patient safety incidents software) and were confident to use it. They reported incidents such as people's bodies arriving in the area with no identification. This happened on average once every three to four months.

Environment and equipment

- People reaching the end of their life were nursed on the main wards in the hospital.
- The hospital was in the process of changing from Graseby syringe drivers to McKinley T34 syringe pump drivers in accordance with the 2011 NPSA alert, which all hospitals must implement by no later than 31 December 2015.
- The syringe drivers had been used to train staff in how to use them. However, they were not being used on the ward at the time of our inspection because of service/ maintenance requirements.
- The mortuary had 40 fridge spaces, which included four spaces for bariatric patients.
- There was a CCTV in the viewing room to safeguard people's bodies during viewings after death. This footage was deleted after 30 days**.**

Medicines

- A trust pharmacist thought that the EoLC prescribing was very good and fully compliant with NICE guidelines on opioid management. They told us that pre-emptive medication, prescriptions and pain control were prescribed appropriately and accurately.
- There were no concerns regarding the availability of pre-emptive medication. All wards were well stocked and had access to the medication on demand.
- Syringe drivers used to administer regular continuous analgesia were being standardised in response to the NPSA alert.
- Patients discharged out-of-hours were provided with emergency medication until the pharmacy re-opened. The remaining medication was dispensed retrospectively

Records

- The trust had developed the CCA end of life guidance to replace the Liverpool Care Pathway. It helps staff to identify deterioration in a patient's condition, and indicates if a patient is dying. The CCA supports staff shape an individual patient care plan that includes a daily recording tool.
- The CCA was implemented two months ago and was due for audit on in January 2015. Staff that had used it said it was useful and helped guide them in how to support a patient during the dying phase.
- We reviewed five CCA records. Entries were made largely by nurses and junior doctors. In one of the five CCA records we noted that the palliative care consultant, a dietician and chaplaincy had made entries. In the four other records the named responsible consultant was not named. The palliative care specialists were involved in all patients with a CCA, and their comments and conversations were clearly presented.
- The mortuary had clear processes, systems and records for eye retrieval with Moorfields Eye Hospital NHS Foundation Trust. The mortuary did not deal with any other aspects of organ donation.

Safeguarding

- All hospital staff, including volunteers, had received safeguarding training appropriate to their job and role.

Mandatory training

- Staff reported that it was easy to keep up with training requirements through the tracker system.

Assessing and responding to risk

- The hospital used National Early Warning Score (NEWS) for acutely ill patients. NEWS is a simple system that hospital staff used to assess whether patients are developing potentially life-threatening illnesses through a number of clinical observations. The aggregated scores indicate the clinical risk to the patient. An aggregated score of 1-4 is a low clinical risk, 5-6 is a medium risk and 7 or more is a high risk. Each score triggers a clinical response and frequency of monitoring.
- The palliative care specialists responded to requests to see patients within 24 to 48 hours. Patients were assessed for treatment by the CNS to ensure an appropriate response as soon as the referral was received.

End of life care

- It was noted on three DNA CPRs that the patients' status had not been reviewed despite an improvement or stabilisation in their condition. This breached the trust's DNA CPR policy.
- We found that a CCA had not been put in place for some patients, who had agreed to a DNA CPR. When we discussed this with one doctor they agreed that a CCA would be appropriate and they would discuss it at the next ward round.
- It was not always known if a patient admitted to A&E from the community had a DNA CPR or not. This could mean patients are resuscitated and provided with fluids and antibiotics unnecessarily. Staff told us there was a need for better liaison between the hospital, community and GPs to ensure best practice and adhere to people's wishes.

Nursing staffing

- The trust had: two breast cancer nurses specialists; a clinical nurse specialist for lung, haematology, chemotherapy and uro-oncology; and two palliative care nurses (one newly appointed).
- The two full-time specialist palliative clinical nurse specialists supported cancer and non-cancer patients in the trust.
- There were no end of life link nurses on individual wards.

Medical staffing

- For a trust of this size it is recommended there should be 1.1 or 1.2 whole time equivalent (WTE) specialist palliative care consultants. The trust had a maximum of 0.2, which was provided by a visiting consultant who was the lead clinician for the Ealing and Hounslow Specialist Palliative Care Service. This meant they were providing one-sixth of the on-site cover recommended. The consultant worked at the Meadow House Hospice based at Ealing hospital. This post was not hosted by the trust and the sessions were purchased from Meadow House hospice.
- The consultant visited the hospital on two half days each week. Outside of these hours specialist consultant support was available through the hospice via telephone. A hospice consultant could attend the hospital if necessary, but we were told that in practice this rarely happened.

Patient affairs, mortuary and chaplaincy

- The palliative care specialists liaised closely with the chaplaincy to offer emotional and spiritual support to patients, their families and friends.
- The mortuary team had a weekly catch up meeting led by the manager. Staff were informed of local issues, changes in policy and procedure and trust-wide concerns or learning.

Major incident awareness and training

- The mortuary area had the capacity to provide nine extra fridge spaces in the event of an emergency. In the event of a major disaster the mortuary liaised with the disaster victim identification team that would attend the hospital with a coroner.
- People who died as a result of violence or a crime were taken directly to the coroner's mortuary.

Are end of life care services effective?

Requires improvement

The palliative care specialists were following best practice guidance and provided advice and support to staff. Nursing staff on the wards provided care with limited knowledge and pathway tools to assist them. Trainees and new staff received some EoLC training. However, staff who had been at the trust a while depended on previous knowledge and their own interest.

We found that there was no acute oncology service at the trust. Cancer patients in A&E were not reviewed on admission to assess them for possible cancer treatments, or for end of life care. This is also against the established standard, and is likely to lead to failures to detect the need for and delivery of active management of various malignant conditions. The trust stated that all haem-oncology patients are reviewed on ward admission 7 days a week.

There was limited monitoring of patient outcomes in relation to end of life care taking place across the trust. There was no action plan to address the low scoring areas of the National Care of the Dying Audit Hospitals (NCDAH) 2014.

Thirty out of a possible 52 specialist palliative care MDT weekly meetings took place over the last year. They included the consultant and CNSs, but did not include

social workers, allied health professions or radiology and they had no clerical support. There was no evidence of specialist palliative care input to any of the site-specific cancer MDT meetings that took place at the hospital.

DNA CPR forms were inconsistently completed. Assessing capacity specifically for resuscitation decisions did not appear to be routinely documented. There was no standardised form used for mental capacity assessments. Nurses and healthcare assistants were aware of patients who did not have mental capacity, but unaware of where this information was documented.

Evidence-based care and treatment

- The trust participated in the NCDAH. The report published in May 2014 showed the trust score met the England average in two out of 10 of the clinical national targets, and was worse than the England average for six national targets. The remaining three were better than the national targets. The trust did not achieve four out of seven of the organisational national targets. The trust's executive lead spoke of their future aspirations to address the outcomes. However plans for this are in the early stages.
- The trust participates in the London Cancer Alliance network. The palliative care specialists spoke positively about the findings, and how they were improving services as a result. For example, in targeted training for FY1 and FY2 doctors in subcutaneous medication prescribing.
- The trust had taken action in response to the 2013 review of the Liverpool Care Pathway, removed it from use and developed the CCA end of life guidance. It had been running for six months and was due for audit on its success and implementation in January 2015. Staff thought that the CCA was a replacement for the Liverpool Care Pathway. However, the palliative care specialists told us it was a tool for staff to provide an holistic approach to care for patients in the last weeks of their life, and not only the last days/hours.
- The palliative care specialists produced an annual report for specialist palliative care services at West Middlesex University Hospital NHS Trust for April 2013 to March 2014.
- The resuscitation team were responsible for auditing in-hospital cardiac arrests (CA). From January to September 2014 there were a total of 131 in-hospital CAs. However, only 34 sets of notes were audited. This was because the resuscitation team did not receive audits forms for every CA from a staff member present at the time. They had received 14 audit forms out of the 131 in-house CAs. The resuscitation team traced another 20 patient notes, but found it hard to locate other CA notes.
- We looked at a sample of 40 DNA CPR forms across a number of wards throughout the hospital. We found the majority were completed appropriately, and relatives' involvement was recorded. This included decisions to withdraw or cancel DNA CPRs.
- We found a number of reasons why some DNA CPR forms had not been completed appropriately. For example, a number had incomplete records or checks and countersigning by a consultant had not been done in a timely manner. In some cases there was no list of irreversible medical conditions where attempting resuscitation is inappropriate: delirium; dehydration; and Down's syndrome.
- The palliative care specialists said that in their experience not all DNACPR forms were completed correctly or completely.
- DNA CPR forms were audited by the resuscitation team on a six monthly basis.
- The resuscitation policy (due for review in 2015) was referenced to the Resuscitation Council, British Medical Association and Royal College of Nursing's joint statement on CPR. The policy was also cross-referenced to other services such as children and young people's resuscitation and palliative care policies. This included compliance with the Mental Capacity Act (2005).

Pain relief

- In the NCDAH for prescribing medication for the five key symptoms (pain, agitation, nausea, noisy breathing and dyspnoea) that patients may develop during dying, the trust scored 26%. This was significantly worse than the England average of 51%.
- Records showed that patients at risk of deteriorating, and who may need additional medication to alleviate their symptoms, had medicines prescribed in advance to minimise patient waiting time and discomfort.
- One out of the three family members' friends we spoke with reported that their relative or friend did not receive enough pain relief, and was left for a considerable amount of time.
- We found no concerns regarding the availability of pre-emptive medication. All wards were stocked well and there was access to medication on demand.

End of life care

Nutrition and hydration

- The trust's 24% NCDAH score in the review of the patient's nutritional requirements was worse than the England average of 41%.
- The trust NCDAH score of 52% for review of the patient's hydration requirements was slightly better than the England average of 50%.

Patient outcomes

- According to the palliative care specialists annual report for April 2013 to March 2014 they received 336 referrals. The patient referrals included 34.5% who had a non-cancer diagnosis, 65% who had a cancer diagnosis and for 0.5% there were no primary diagnosis documents.
- The palliative care specialists did not see 27 (8%) of the patient referrals. The majority of these were because the patient had died before they had an opportunity to review them, and the rest because the patient had been discharged. A small percentage were referred inappropriately. The specialists told us that referrals were often made too late for them to consult on.
- In the NCDAH the trust scored 65% for reviewing interventions during a patient's dying phase, which was better than the England average of 56%. However, they scored 65% for reviewing the number of assessments undertaken in the patient's last 24 hours of life, which was worse than the England average of 82%.
- During January to September 2014 there were a total of 131 in-hospital CAs, and the in-hospital CA audited 34 sets of notes. The results showed that 80% of patients were accurately scored using NEWS, and as a result: the frequency of observations increased in 20% of the cases; 46% of patients were escalated appropriately; and 27% of patients were reviewed by an appropriate doctor. The audit identified the need to continue training on the recognition of the deteriorating patient by retraining nurses and healthcare assistants in observation skills, accurate charting and totalling of the NEWS chart. The recommended training also included the importance of escalating care.
- The audit looked at whether patients with a score of five or over triggered the completion of a DNA CPR. The results showed that this had occurred only once, or in 3% of the sample. A further nine DNA CPR forms were audited for patients with a lower score. This showed that in the majority of cases most of the sections were completed appropriately and accurately.
- However, the July 2014 DNA CPR audit for elderly patients who may have a CA showed that in 43% of cases the sections on the DNA CPR form were incomplete or inappropriate. For example, one form stated 'for palliative care'. In 45% of cases there was no documentation to say that the patients' care had been escalated, or that they had been referred to the critical care outreach team.
- The audits had identified the need for consultants to be reminded during mandatory training about the importance of role modelling the DNA CPR process and documentation to junior members of staff.
- The trust scored 68% 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 better than the England average of 59%.
- Mortuary staff performed regular audits and checks to ensure that best practice and procedures were followed, particularly out-of-hours. The mortuary manager undertook an annual inspection that included inspecting the fridges and records.

Competent staff

- The trust did not have EoLC champions on each ward and relied on staff who had an interest in EoLC to support staff on the wards.
- The palliative care specialists provided formal and informal EoLC training to junior doctors and new nursing staff. However, there was little opportunity for established staff to receive training, and they relied on personal interest and what they had learnt during their training. The trust was planning to recruit an EoLC nurse who could co-ordinate the learning and to support staff when needed.
- There was a mixed response from staff to the training or the introduction they received about the CCA. Some had had a one-to-one briefing, while others were aware of its existence they had not received instruction on how to use it. All new trust staff had received EoLC information about the CCA during induction.
- New nurses and healthcare assistants receive a tour of the mortuary to dispel any fears or myths, and to give them confidence in how to support grieving families and friends when they accompany them to the area.
- Mortuary staff reported receiving good accessible training. They told us of a seminar they attended on

developing coping strategies and dealing with their own feelings around death. Another member of staff had been supported in training as a grief and bereavement counsellor.
- Porters were trained by mortuary staff on how to handle bodies with care and dignity, procedures and protocols within the mortuary area, and safe back care.

Multidisciplinary working

- The trust scored 47% for multidisciplinary team recognition that a patient was expected to die within the coming days or hours, which was worse than the average England score of 61%.
- According to the palliative care specialists annual report for April 2013 to March 2014 there had only been 30 MDT weekly meetings out of a possible 52 weeks. The MDT meetings included the CNS, consultant and MDT co-ordinator. They discussed the patient's key needs such as psychological, spiritual and physical, and a suggested care plan was written on a sticker signed by the consultant and applied to the patient's records.
- There was no dedicated multidisciplinary meeting between the wards, palliative care specialists, occupational therapy, social workers and chaplaincy to discuss the needs of dying patients.
- The palliative care specialists had no input to any of the cancer site-specific MDTs in the trust such as breast, lung or colorectal cancer.
- The patient affairs office received a daily list of patients who had died in the hospital the previous day. The medical notes were delivered to the office and checks would be made with the ward doctors to find out whether any case needed to be referred to the coroner's office.
- The patient affairs office reported good working relationships with the wards, CNS, chaplaincy and mortuary staff. They also had easy access to West London Coroner's Court and the coroner's mortuary at Fulham.

Seven-day services

- The palliative care specialists were available at the hospital during working hours from Monday to Friday.
- Out-of-hours support services were provided by Meadow House Hospice in Hounslow.

Access to information

- The palliative care specialists were aware of co-ordinate my care (CMC). This is an electronic recording system used to share information between patients' healthcare providers such as the GP, hospitals and ambulance. It means that health professional know a patient's wishes about how they would like to be cared for. Take up for this system was poor, although staff were aware that it would benefit patients because they would be able to honour their wishes in a more timely way. Staff thought that local GPs should be the appropriate channel to increase use of CMC.
- Patients with a CCA had their preferences and wishes documented in their records. There was a proforma that could be faxed, or emailed to the patient's GP to advise them that their patient had deteriorated and a CCA had been implemented to manage the terminal phase. Only one of the five CCAs we reviewed indicated that the hospital had informed the patient's GP of a patient's terminal phase.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- The trusts DNA CPR policy states 'if a patient lacks capacity to contribute to a decision about resuscitation, the assessment of capacity must be documented in their health records and any decisions must be made in the patient's best interest and must comply with the Mental Capacity Act (2005) (Appendix A: Section 9).'
- Assessing capacity specifically for resuscitation decisions did not appear to be documented on a routine basis. We found that assessment of capacity was documented in medical notes as a mental state examination. It used abbreviated mental tests to examine a patient's ability to understand, retain and explain information. There was no standardised form used for mental capacity assessments.
- Nurses and healthcare assistants were aware of patients who did not have mental capacity, but were unaware of where this information was documented.

Are end of life care services caring?

Requires improvement

We found people's experience of care; understanding and emotional support was mixed. Some people we spoke with said they could not fault the care ward staff gave. People described it as "marvellous". They also told us they were treated well and kept informed.

End of life care

However, some people experienced care that lacked compassion, understanding and emotional support. The attitude of a number of ward staff was dismissive, and advice and information was inconsistent, particularly for patients who moved between wards. This was confirmed in the types of complaints the hospital received about EoLC.

We found when the specialist palliative care CNS was brought in to help manage a dying patient that the patient and relatives had received a good level of care, felt involved in discussions, decisions and had a clear understanding of the support being given. However, this was entirely dependent on involving the CNS sat an early stage.

We found the care and support given to relatives after the death of their family member by the mortuary staff and patient affairs office to be exemplary.

Compassionate care

- Relatives and staff were in agreement that the palliative care specialists provided compassionate and considerate care to patients at the end of their life. They were described as "exemplary".
- We spoke with relatives of patient who had died or were likely to die at the hospital. There was a mixed response about how compassionate ward staff were. Relatives described some staff as kind, calm, considerate and friendly. While other staff were described as dismissive and uncaring. One patient was told to "do it in the nappy we put on you" when they asked for help to go to the toilet. This left them embarrassed and undignified in front of their visitor. They were left in the soiled pad for over two hours.
- Since 1 January 2014 there had been 18 complaints about EoLC at the hospital, 11 were complaints about the care and treatment of their relative prior to their death and four related to the attitude of staff.

Patient understanding and involvement

- The trust scored 76% in the NCDAH for the national target for health professionals' discussions with the patient and their relatives/friends about their recognition that the patient is dying. This was the same as the national average.
- The trust scored 53% for communicating the patient's plan for care in the dying phase, which was slightly worse than the national average.
- Most of the relatives we spoke with told us they thought the staff communicated well and regularly. Relatives said they felt involved in their family members care. One person told us "staff were very understanding and answered all our questions". However, this was not the case for all the relatives we spoke with, particularly if the patient was moved between wards.
- Three of the 18 complaints to the hospital about EoLC concerned the lack of communication, information and explanation prior to their relative's death.

Emotional support

- We observed the CNS supporting patients during a ward round. They were enquiring, comforting and listened patiently to all the questions families and patients asked them.
- We did not see any formal evidence for assessing a patient's anxiety or depression levels such as hospital anxiety and depression (HAD)scale. This relied on the CNS knowing the patients and recognising a difference in their mood.
- The chaplaincy was available to offer emotional and spiritual support to patients and their relatives.
- The chaplaincy had links with other religious leaders in the community, who would visit patients and relatives who requested support from leaders of their own faith.
- Hospital volunteers specifically trained in supporting patients and families through dying visited the wards. The volunteers came from a number of different faiths.
- The trust's score in the NCDAH for assessment of the spiritual needs of the patient and their nominated relatives or friends was 9%, which was worse than the national average of 37%.
- It was thought that the low score was because ward staff asked patients and families them about their spiritual support needs too late. There was also confusion between spiritual and religious needs. When the palliative care specialists were involved spiritual support was offered far earlier.
- The patient affairs office supported relatives/friends after the patient's death by explaining all the legal processes, and what to expect after someone has died. An information pack included the contact details for support and counselling groups.
- Staff in the patient affairs office told us they always supported families or friends wishing to see the deceased by accompanying them to the place of rest/ viewing room.
- A Macmillan information centre is available in the main entrance area to the hospital and the Mulberry Centre is

an additional resource available on site for patients with cancer. Centre staff offer advice and signpost patients and their families to where they can obtain further support.

Are end of life care services responsive?

Good

The palliative care specialists provided dedicated care across the hospital and community. There was limited evidence of a trust-wide approach to deliver end of life care that was not reliant on the palliative care specialists.

Where possible patients reaching the end of their life were cared for in side rooms. There were private rooms available near to most wards to have private conversations with patients and relatives. We were told that a member of ward staff or the patient affairs staff always accompanied family and friends of the deceased to the mortuary viewing area if they wished to spend time with their relative after death.

The palliative care specialists were able to arrange rapid discharges to a care setting. The social service department reported that discharge arrangements worked well. However, the medical director reported that there were a large number of in-hospital palliative care deaths due to the challenges the hospital and community face in supporting patients dying at home.

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

The bereavement and mortuary services took into account people's religious customs and beliefs, and were flexible around people's needs such as releasing the body and providing death certificates within 24-hours.

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.

Service planning and delivery to meet the needs of local people

- From April 2013 to March 2014 there were 714 deaths in the trust, and the figure for April 2014 to August 2014 was 261.
- When appropriate the hospital together with the hospital-based social services and occupational therapy team provided a fast track discharge for patients who wished to die at home, in a hospice or nursing home. Staff told us of several examples of how they supported patients who wished to die in the place of their choice.
- Local authority registrars had spent a few years trying to develop a registration service based in the hospital. A six-month pilot was so successful that a registrar was permanently based in hospital for 2 days-a- week. They had received good patient and relative feedback about the hospital-based registrar service.
- Relatives and friends could arrange an appointment to view their family member's body. This was usually organised through the patient affairs office with ward and mortuary staff.
- The patient affairs office managed funerals for people without a next of kin. They planned a dignified funeral for the deceased and referred people to the treasury solicitor if they had an estate of value.
- There were sensitive arrangements for miscarried and stillborn babies. Parents who lost their baby at less than14 weeks were offered communal burials or cremation if they did not wish to make arrangements. The parent(s) could attend these ceremonies, but if they didn't want to they were informed of the time of the burial or cremation should they wish to mark the moment personally in some other way. Parents who lost their child after 14 weeks were offered an individual burial or cremation. These records were kept for years on the computer system because some families might want to know what happened to their baby several years after the event.

Access and flow

- The palliative care specialists received referrals from any hospital team and also from community teams such as district nurses and GPs. They accepted referrals for any adult patient who needed specialist palliative care input. The also provided telephone support and signposting for teams who only required advice.
- Hospital referrals were made through the Order Communications System as with other referrals for specialist advice. Referrals were picked up at 9.30am each day by the CNS. Urgent referrals were input on the IT system and followed up by a telephone call to the CNS.
- If the CNS was absent or it was out-of-hours, staff contacted Meadow House Hospice to request a discussion or consultant review.

End of life care

- There were two pathways for patients who wished to die at home or in a hospice. The first is a planned discharge for patients who may have been, or will be, in palliative care for a while. The second pathway is the NOW 9 discharge for patients who had days or hours to live. The palliative care specialist discharges patients to their GP and arrange appropriate support from the community palliative care and district nursing teams. The GP had to be prepared to sign the patient's death certificate before the patient could be discharged to their home.
- Patients discharged home out-of-hours were supported by the Marie Curie rapid response team in the London Borough of Hounslow, and a twilight service in the London Borough of Richmond that ran from 6pm to 7am. The team told us of one patient who was in the last hours of their life and who was discharged to their nursing home in an hour and 15 minutes of the decision so that they could die in the place of their choice. They also told us of a patient who lived too far way to be transferred back to their home to die, so they made arrangements for them to die at a relative's home.
- We spoke with the social service department at the hospital. They told us there was a good working relationship with staff in the hospital to arrange to fast track patients to their home, nursing home or a hospice. They received one to two fast track requests per week. We were told that there were good arrangements with the CCG to approve funding.
- The mortuary reported a good relationship with the contracted funeral directors. If the hospital mortuary was full they would access more space with the funeral directors and make arrangements for other funeral directors to remove the bodies released to them more quickly.

Meeting people's individual needs

- 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, despite the national recommendation that it should be provided. However, there was 24 hour access to on-call advice from the consultants and local hospice.
- The lead consultant told us that most of the referrals to the palliative care specialists were late and did not allow time for staff to talk properly with patients and relatives about their needs and wishes. This was confirmed in the hospital's specialist palliative care services annual report, which indicated the main reason for not reviewing a patient was because they had died before a review could be done.
- Staff reported an inappropriately high number of in-hospital deaths for patients receiving palliative care. They told us palliative care support was not only a challenge to the hospital, it was also challenging to the wider community because there of the limited palliative care support available. This meant it was hard to arrange for people to die in more appropriate surroundings such as home or a hospice. A newly-established group made up of the hospital and community GP leads has a remit was to look at how to improve palliative care in the community and links with the hospital.
- 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.
- There were no beds specifically identified for end of life patients, although staff reported they tried to identify side rooms to provide privacy. We noted at our unannounced inspection that a newly-admitted patient who was in the dying phase of their life had been provided with a side room on one ward. They had their family members with them.
- Family rooms and overnight accommodation was not available other than in the children's ward. However, there was no restriction to visiting patients coming to the end of their life.
- The trust employed a chaplain 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. We noticed at our unannounced inspection a remembrance tree had been put up outside the multi-faith room and chapel. Friends and relatives could write a message, their thoughts and name of a loved one on a tag or piece of card that was hung on the tree.
- The bereavement and mortuary services took into account people's religious customs and beliefs, and were flexible around people's needs such as releasing the body within 24-hours.

End of life care

- Death certificates were issued within 24-hours if everything was in order. This could be sent to families if they preferred. The patient affairs office gave the body release form to families or the funeral director if the family lived far away.
- A&E had a relative's room and viewing room for families who wished to spend time with the deceased.
- There was a dedicated viewing room in the mortuary area with a waiting area and toilet. The room was neutral, lights could be dimmed, clean and tidy. It did not display any religious paraphernalia.
- Translation and interpreting services were available for people who didn't speak English.

Learning from complaints and concerns

- Patients and their families were directed to the PALS office for support to make a complaint or to request a meeting with the senior medical officer if they had concerns. Relatives were directed to the wards or their GP if they were not happy with, or did not understand their relative's cause of death.
- PALS told us they had not received any complaints specifically about patients receiving EoLC.
- The patient affairs department were unaware of any particular complaints or issues in relation to EoLC.
- The complaints department had received 18 complaints since January 2014 about patients who had died on the wards. A majority of complaints were about poor communication, particularly leading up to a patient's death and post-death. There was some concern about the poor attitude of staff on some wards towards patients and families. We were not provided information about the investigation and outcome of each of the complaints.

Are end of life care services well-led?

Requires improvement

There was no formally agreed trust strategy for end of life care. EoLC did not appear to have a high profile in the trust. There appeared to be a lack of clarity from staff about who had responsibility for EoLC at board level. The trust medical director had recently been appointed to lead on EoLC at board level, but this was relatively new and had not filtered through to staff.

Historically, end of life care was actively led by the palliative care specialists and chaplaincy. However, the executive lead and palliative care specialists were in agreement that end of life care was everyone's business. The future aspiration is to reinvigorate the subject across the hospital to raise the profile for EoLC.

There were limited governance systems, although some audits had taken place and more were planned for the coming months. The palliative care specialists reported an increase in demand, and one extra CNS had been recently employed to provide support on a daily basis. However, there appeared to be no plans to increase consultant cover to the national requirements for a trust of this size.

We found the sub-contracted palliative care consultant was providing good, but limited leadership at local level. There was insufficient consultant cover to provide effective leadership overall for the service. The medical director told us about their vision for the EoLC service to re-focus the services and present new terms of reference and actions to the trust's board.

Vision and strategy for this service

- The results from the NCDAH formed the basis of the CCA. It was felt that the results from the CCA January audit would form the direction the trust needed to take to improve patient experience when they were coming to the end of their life.
- In the past EoLC had been seen as the responsibility of the palliative care nurse and chaplaincy. The new medical director (MD) was clear that to increase the EoLC profile all staff needed to understand that dying was everyone's business.
- The MD's aim was to re-invigorate the EoLC group and from this get a clear action plan to present to the board. The MD said this group was the platform for them to increase their profile and responsibility.
- The palliative care specialists told us they had increased the profile of EoLC in the trust over the last six months, but it was still at an early stage. They told us there had been as increase in dialogue with wards and other colleagues. They spoke positively about the MD, who they said appeared passionate about EoLC.
- The EoLC group had recently met after a break, but there was no indication of their terms of reference or

who they reported to. It was intended that the MD would join the meetings and report to the patient experience committee and clinical governance committee. However, this had not happened.

Governance, risk management and quality measurement

- The trust medical director (MD) was the lead for EoLC together with the deputy nursing director. The external palliative care consultant supported the clinical decision-making for each patient.
- EoLC did not have a service-specific performance dashboard, and we found no evidence that it featured in any of the trust performance measurements.
- We found no evidence that EoLC issues were on the local or overall trust risk register.
- The palliative care specialists found it hard to audit their work because the trust did not have an electronic system to record all palliative care and end of life data. They collected printed referrals, weekly patient lists and MDT documentation to write their April 2013 to March 2014 annual report. It was noted in the report that the activity data was likely to underestimate their current activity because the data collection system used was not robust and did not include activity such as telephone conversation and advice between the specialists and the local hospice.

Leadership of service

- There had been five different leads for end of life care at board level, and other key staff had also changed. It was thought that the inconsistency and staff changes had caused the profile of EoLC in the trust to decrease and resulted in some poor figures in the national audits. The new MD spoke enthusiastically about re-invigorating EoLC across the trust to create a clear team structure.
- EoLC had recently moved from the surgical division into the medical division, also taking the two CNS into the medical division.
- The patient affairs office spoke positively about communication from the chief executive and in the trust. They told us they felt a part of the wider hospital team and not side-lined.
- The mortuary staff reported a good relationship with their line manager describing them as being easily accessible. They felt positive about the trust's leadership and described the trust as "transparent". Staff told us the chief executive had visited their department twice and took time to find out about their work. They told us they felt it was a worthwhile visit and the chief executive had appeared engaged with their work.

Culture within the service

- The visiting consultant and palliative care specialists were committed and worked hard to support as many patients, families and staff as they could to support dying patients. The palliative care specialists reported good working relationships with the chaplaincy and that ward staff knew who they were.
- The registrar said the hospital staff had been really friendly and welcoming. They had been included as part of the wider hospital team and provided with good equipment, office facilities and IT access.
- The mortuary team were very proud of the high standard of their work and described themselves as "nurses for the dead".

Public and staff engagement

- The hospital-based registry office and palliative care specialists took part in hospital open days. They spoke positively about the open days and gave us an example of a poor experience a relative shared with them that resulted in some changes to communication methods. The relative has regularly updated the team on whether the changes were effective. They were prepared to share their story at the following open day to show how a negative experience can create a positive change.
- The CNS told us they had not received feedback about the outcomes from the cancer peer review process to improve the service provision. They also have not seen or heard from the lead people in their cancer network alliance.

Innovation, improvement and sustainability

- The future aspirations for the service were to increase the profile of EoLC in the trust and provide all staff with the tools and confidence to support dying patients and their families through an intranet page. They were looking at adopting One chance to get it right published by the Leadership Alliance for the Care of Dying People in 2014.
- The service was involved with the CCG's clinical quality group, and were discussing the development of

community-based palliative care services and improving contact with other local community healthcare providers to support patients dying in the place of their choice.

Outpatients and diagnostic imaging

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

Information about the service

The outpatients and imaging department has clinics throughout the West Middlesex University Hospital NHS Trust. Some clinics are located in the main outpatient areas, while others are in different parts of the hospital. There are a number of specialities in the outpatient department that include: breast and fracture clinics; dermatology; ear, nose and throat (ENT); audiology; general medicine; cardiology; oncology; diabetic medicine; endocrinology gastroenterology; general surgery; and other clinics. The outpatients and diagnostic imaging department is advertised as open on Monday to Friday from 8am to 5pm.

Blood test (phlebotomy) services are provided in outpatients. The imaging department supports outpatient clinics as well as inpatients, emergency services and GP referrals. The diagnostic imaging department carries out x-rays, computerised tomography (CT), interventional imaging, fluoroscopy, and ultrasound. The magnetic resonance imaging (MRI) service is provided by a private contractor based on the hospital site. We visited the provider to discuss the operation of the service they provide to outpatients.

We visited all the clinics and the diagnostic imaging department, observed activities, checked equipment and looked at patient information. We spoke to: 33 patients; three department managers; six nurses; two doctors; five relatives of patients; three health care assistants; and two support and administrative staff. Patients with an outpatient's appointment used the self check- in services at the main hospital entrance before making their way to their clinic.

Outpatients and diagnostic imaging

Summary of findings

There were policies and procedures in place to support a safe service for patients using the outpatients and diagnostic imaging department. Staff were caring and treated patients with dignity and respect. Medicines were securely stored in a locked medicines cupboard, and other medicines that require refrigeration were kept in a fridge in all the clinics visited.

The outpatient and diagnostic imaging areas were clean and equipment was maintained. We noted that daily cleaning schedules were not maintained in some clinics. In other clinics where cleaning schedules were maintained the records were very poor at best, and in some cases non-existent.

There were some areas in need of improvement to ensure that clinics ran on time and the number of cancelled clinics reduced.

We noted that hospital staff actively sought patients' opinions to improve services. There were positive comments about the care and treatment from outpatient and diagnostic imaging department patients. All said they would recommend the service to their friends and family.

Overall there was a sufficient number of staff to run all the services. Incidents related to safeguarding were appropriately recorded and actions were taken to address them.

Are outpatient and diagnostic imaging services safe?

Good

The outpatients and diagnostic imaging department provided a safe service to people who attended outpatient clinics and diagnostic imaging services. There was an electronic incident reporting system and staff were aware of how to report incidents. Staff we spoke with told us they received feedback whenever they reported an incident and were informed of action taken.

We noted that the service areas were clean and tidy. However, recording cleaning schedules was poor. Infection control policies and procedures were in place and were followed by staff to ensure the safety of staff and people who visited the department. There were hand hygiene facilities in all areas of the department.

Incidents

- The department recorded three incidents from January 2014 to December 2014. None was classified as a serious incident.
- There have been no recent Never Events (serious, largely preventable patient safety incidents that should not occur if proper preventative measures are taken) or serious incidents reported in outpatients or diagnostic imaging department.
- All staff we spoke to knew how to report incidents and were encouraged to do so by their line managers.
- Staff stated that they were encouraged to report incidents and received direct feedback from their line managers. Staff gave us examples of where practice had changed as a result of incident reporting. For example, an incident in the imaging department led to the development of a patient information checklist as an added security measure for patients having a CT scan.
- Staff told us they were confident in raising any concerns with their line managers. Senior managers met regularly to discuss compliments, complaints and incidents. Themes from incidents were discussed at these meetings.
- Staff we spoke with told us they learned from incidents across other parts of the trust through the trust bulletin.

Outpatients and diagnostic imaging

Cleanliness, infection control and hygiene

- Hand-hygiene gel dispensers were located at the entrance to each clinic and were also available at other locations throughout the department.
- Patients we spoke to all told us they felt the department was cleaned to a good standard.
- During our inspection we walked around the department and checked the cleanliness of: the patient waiting areas; clinic/treatment rooms; patient toilets; dirty utility rooms; and corridors. We found a good standard of cleaning.
- We asked for the daily cleaning schedule in three outpatient clinics, but none was available. They were available in some clinics, but the record had not been completed in full. We saw examples of schedules that had not been filled in every day and the daily record sections of the schedule were left incomplete.
- Mandatory training records at both the outpatient and diagnostic imaging department showed that all staff had received infection control training in the past year.
- Staff we spoke with understood their role in the prevention and control of infectious diseases.
- We observed staff washing their hands and using personal protective equipment (PPE) such as gloves and aprons when required.
- Blood test (phlebotomy) services were provided in a clinical room to maintain patients' privacy and dignity.

Environment and equipment

- The environment in the outpatient and diagnostic imaging department was safe and fit-for-purpose.
- We looked at resuscitation equipment and found that it had been cleaned appropriately, checked and ready for use. The resuscitation equipment is checked and signed daily.
- There was adequate equipment available in all areas. Staff confirmed they had enough equipment to work with and had been trained to use it.
- Resuscitation trolleys were centrally located and were close to the areas they covered.
- Single-use items were sealed and in date. We saw annual maintenance records of the resuscitation/ emergency equipment.

Medicines

- Medicines were kept in a locked cupboard, and those that required refrigeration were kept in a fridge.
- Fridge temperatures were checked daily to ensure medicines were stored at correct temperatures.
- Staff told us they were trained in medicines management and were aware of their responsibility in the safe administration of medicines.
- We asked for an audit on the use of medicines at the outpatient department and were told that this had never been done.

Records

- Medical records were kept in the administration offices of the outpatient department. However, the records were not kept in a locked cupboard as they should be. We found that the records were either on or underneath the desk in those offices.
- There was written guidance for staff regarding confidentiality of handling medical records.
- There were no issues raised about lack of access to full patient records, and staff said that patient medical records were available for clinic appointments at all times.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

- We found nursing staff understood the Mental Capacity Act (MCA) 2005 and how this related to their area of work.
- Nursing staff told us they had Deprivation of Liberty Safeguards (DoLS) training. We noted from training records that all the staff working at the outpatients and diagnostic imaging department have attended DoLS training.

Safeguarding

- The hospital has policies for safeguarding children and vulnerable adults. Staff we spoke with were aware of the safeguarding policies and procedures, and they knew how to raise a safeguarding alert.
- All outpatients and diagnostic imaging department staff had completed safeguarding training as part of mandatory training programme.

Mandatory training

- Staff told us they had undergone mandatory training including basic life support and health and safety awareness training.
- The staff we spoke with also informed us they had been on training relevant to their role in the outpatient and diagnostic imaging department.
- Service managers told us there was good availability of training opportunities and staff were encouraged to take responsibility for organising their own training dates.

Outpatients and diagnostic imaging

- Every member of staff had a training record, which were kept electronically on the trust intranet site.
- The service managers for outpatient and diagnostic imaging were able to see what mandatory training had been completed by staff and what was outstanding in their departments.

Assessing and responding to patient risk

- The hospital has systems and processes in place to respond to patient risk.
- All patients are risk assessed by nurses before being sent home after their appointment. If a patient is considered unfit to go home they will be admitted to the hospital. The bed management team is contacted to arrange the admission.

Nursing staffing

- Both staff and managers told us there were enough trained nurses and healthcare assistants working in the department.
- We observed nurses attending to patient needs in each of the clinic visited.
- The patients we met told us their appointments were on time or had minimal delays at the time of the inspection. They told us staff made them aware of delays and kept them informed.
- However, we noted during the unannounced part of our inspection that the clinics were short staffed and there were delays of up to an hour in some clinics.

Medical staffing

- The medical staff said they felt the clinics ran efficiently with adequate staff cover.
- One doctor said there were times when there were not enough nursing staff to ensure the clinics ran smoothly.

Major incident awareness and training

- There was a major incident and business continuity plan drawn for the hospital by the emergency planning team. This is in line with the NHS Commissioning Board Emergency Planning Framework, and with other guidance such as the NHS Commissioning Board Command and Control Framework and Business Continuity Management Framework (service resilience).
- Staff we spoke with were not familiar with the trust major incident policy and none of the outpatient and diagnostic imaging staff had been trained on major incident awareness.
- Service managers told us the hospital major incident plan was on the trust intranet and assured us that staff were able to access this as required. The manager demonstrated an understanding of the department role in a major incident, and explained what actions to take in the event of an emergency.

Are outpatient and diagnostic imaging services effective?

Not sufficient evidence to rate

Outpatients and diagnostic imaging services provide care and treatment to patients in line with National Institute for Health and Care Excellence (NICE) guidelines. Suitable clinical guidelines were followed for different patient pathways. Patient consent was obtained appropriately.

We observed staff undertaking their roles, and they worked together as a team to meet the needs of their patients. Staff were competent and knowledgeable, although not all of them had had their appraisals.

The outpatients department operated clinics from Monday to Friday with occasional late evenings and weekend clinics to meet the demand of the patients.

Evidence-based care and treatment

- Patients' needs were assessed, and care was delivered in line with clinical practice and guidelines.
- During our visit the hospital was undertaking a patient survey on access to the outpatients department from the main reception area after they had completed the self-check in process.
- Staff told us that they worked to local policies that were reviewed regularly as part of the governance arrangements for the service.
- Staff we spoke with were able to provide us with evidence on the use and implementation of NICE guidelines in their practice.

Pain relief

- Staff told us that they could give paracetamol to patients if they were in pain, but all other analgesics had to be prescribed before they could be administered to patients.

Outpatients and diagnostic imaging

Patient outcomes

- We spoke with 16 patients, who were all satisfied with the overall experience of visiting the outpatients department.
- The hospital had undertaken the NHS Friends and Family Test (FFT), and the result showed that most patients said they would recommend the hospital to family or friends.

Competent staff

- Staff were able to explain to us what their role was and told us they were provided with training, development and supervision to ensure they were able to do their job effectively.
- Staff told us they were provided with annual appraisals of their performance and their appraisal was linked to their professional development
- There were no role-specific training standards set by the trust to state what staff had to complete as a minimum for their designated work area. However, there was generic mandatory training for all outpatients and diagnostic imaging staff.

Multidisciplinary working

- The service manager told us there were a variety of multidisciplinary team (MDT) clinics across the department that included: head and neck; colorectal; urology; diabetes; and breast clinics.
- Staff were noted to be working across different clinics: one clinic in the morning and another clinic in the afternoon.
- The trust has an agreement with Alliance Medical (the provider of the MRI service) for imaging staff rotation to their department. However, this agreement was not well co-ordinated. We noted the agreement had not been reviewed for over 12 months and a member of a staff on a 12-month secondment had been with the service for over four years.

Seven-day services

- There were additional non-routine clinics scheduled for evenings and Saturdays to reduce the waiting lists. Staff said the evening and ad hoc Saturday clinics were popular with patients.

Are outpatient and diagnostic imaging services caring?

Good

On our visit we found that the outpatients and diagnostic imaging services were caring. We observed patients receiving care in a compassionate manner and that they were treated with dignity and respect. Patients and relatives commented positively about the care provided to them by the staff from all the clinics visited. Patients told us that doctors, nurses and other health professionals answered their questions and kept them informed of their care and treatment. We saw that patients were given information about their treatment.

Staff who worked in the departments treated patients courteously and with respect. Staff listened and responded to patients' questions positively and provided them with supporting literature to assist their understanding of their medical conditions.

Compassionate care

- We spoke with 33 patients during our visit and their feedback was positive and complementary about the attitude and approach of staff at the outpatients and diagnostic imaging department.
- We observed staff being polite and welcoming. We saw receptionists greeting patients and asking if they could help them.
- We saw nurses calling patients into clinics in a polite manner and greeting them before taken them through to the consultation room.
- The outpatients department had suitable rooms for private consultations.
- Chaperones were offered to patients who needed chaperone services. Where patients attended the department alone and were deemed to be in need of chaperone, one was provided to assist the patient throughout their outpatients and diagnostic imaging experience.
- Staff were observed treating patients with dignity and respect, most patients we spoke with told us they were treated well and were happy with the services received.
- The Outpatients Friends and Family Test (FFT) response rate and ratings (1 November 2014 to 30 November 2014) had a response rate of 19%. Of these 86% of respondents were positive or very positive about the care they received in outpatients and diagnostic services.

Outpatients and diagnostic imaging

Patient understanding and involvement

- Patients we spoke with told us they felt they had been involved in decisions about their treatment and care.
- Patients told us they had received information about their condition and medication, and that any changes in their treatment were discussed with them. They told us they were given the opportunity to ask questions and to make an informed decision about their treatment and care and choices available to them. One patient told us staff had explained their care and treatment and felt staff were friendly and polite.
- Patients told us that they felt able to talk to staff about their concerns.

Emotional support

- Staff told us how they supported patients who have been given bad news about their condition, and offered them sufficient time and space to come to terms with the information.
- Patients and relatives we spoke with told us they had been supported when they were being given bad news about their condition.
- Nurses were available in clinics to help with information and support.
- The trust had chaplaincy, bereavement and counselling services available to patients who needed them. We were shown evidence of referrals made for bereavement counselling by the staff.
- Staff told us there was always a plan in place that included the use of a private room if patients were going to be given concerning news about their health.

Are outpatient and diagnostic imaging services responsive?

Requires improvement

The outpatients and diagnostic imaging services were not responsive to the needs of their patients. There were persistent cancelled clinics with an increasing trend in the last three months prior to the inspection. Many patients experienced delays in their treatment due to lack of planning and staff shortages.

The trust was failing to meet their target of 62 days urgent referral to treatment for cancer. The trust target was 85% and they achieved 81% in 2013/2014.

There were good mechanisms for information sharing with their clinical commissioning groups (CCGs) in the London boroughs of Hounslow and Richmond.

The organisation of clinics was not responsive to the needs of patients. Some patients were experiencing long delays in their appointment time of up to an hour when we visited. Clinics were occasionally cancelled at short notice. On the day of our visit a doctor cancelled his scheduled clinic and this meant that patients had to wait for long periods to be seen or have their appointments cancelled and re-scheduled.

Translation services were available through the language line for people with English as a second language. Most of the staff we spoke with were able to tell us how to access the language line. Complaints were handled appropriately and action was taken to improve the service.

Service planning and delivery to meet the needs of local people

- A number of the patients told us their appointment times were running late by about an hour and half on average. However, they also told us that staff normally informed them when clinics were running late.
- We were told that there was no monitoring in place for clinics that were running late. We saw notices on the board informing patients about delays in the clinics.
- The staff told us they supported patients through busy times by ensuring they were informed of the waiting times and how long it would take before they were seen.
- Patients we spoke with told us that they were informed of the reasons why clinics were running late.
- The service manager told us that the booking of outpatients' appointments was currently semi-centralised. The trust did not have overall control of booking outpatients appointments because they were booked through two CCGs. Each CCG had different appointment systems booking outpatients directly onto the trust's choose and book system.
- The central booking office was open Monday to Friday from 9am to 5pm. Patients were given the choice of receiving a confirmation text message with their appointment details and a reminder text a week before their appointment date.
- Of 11767 appointments cancelled or postponed by the provider in a 12 month period, three causes together

accounted for 8666 or 74% of those cancelled or postponed appointments namely: doctor unavailable for clinic (3070 or 26%);consultant request (3108 or 27%) or inappropriate appointment (2488 or 21%).
- During the unannounced visit we were told that a doctor had called and cancelled a clinic that morning at short notice due to sickness, which caused delays in the clinic schedule.

Access and flow

- We received information from the trust about cancelled appointments. This showed that the trust had high levels of cancelled outpatients appointments.
- The service manager managed cancelled appointments weekly to ensure that any cancelled patient appointment was re-booked as appropriate. Some of the patients we spoke with told us they were offered an appointment within two weeks of their initial cancelled appointment.
- The hospital did not do partial bookings to reduce the high levels of appointment cancellations. Partial booking is a new way to book follow-up appointments. The follow-up appointment is booked straight away, but the patient is asked to contact the hospital nearer the time to confirm the booking. Failure to do this results in automatic removal from the partial booking system, no new appointment is issued and the patient is discharged to their GP.
- The trust has a grading system for their appointments: soon; urgent; and routine. An appointment classified as 'soon' is seen on average within 24 to 48 hours, 'urgent 'within four weeks and 'routine' can take up to 24 weeks with a cut-off point at 14 weeks.
- Waiting times for consultation in the audiology and ENT clinics can take longer because of the type of the investigations such as syringing and x-rays, which takes about an hour.
- The trust 18-week referral to treatment times target for 2013/2014 are:
- Admitted patients target for 2013/2014 was 90% and the trust achieved 95.4%
- Non-admitted patients target for 2013/2014 was 95% and the trust achieved 97.1%.

Meeting people's individual needs

- Patients we spoke with gave us positive feedback about how staff at the outpatients, diagnostics and imaging department met their individual needs.
- There was no clear signage to individual clinics after completing the self-check in procedure at the main entrance. We observed some patients getting lost and asking for directions to their assigned clinics.
- A translation service was available through the language line to enable staff to communicate with patients where English is not their first language.
- Some clinics did not have information advising patients of the waiting time when clinics were running late, while other clinics had information boards advising patients on the waiting times.
- Patients and relatives we spoke with told us they were encouraged to be involved in their care, were listened to and were involved in decision-making about their care and treatment.
- There was written information available for patients. Some of these leaflets had been produced by the trust, and other information materials had been provided by external agencies such as the medical royal colleges.

Learning from complaints and concerns

- We were told by the service managers that each area lead dealt with initial patient's complaints or concerns, and if they were unable to resolve the matter satisfactorily they would direct the patients to the Patient Advice and Liaison Service (PALS) to escalate their complaint or concern.
- We saw written information about the complaints procedure and the PALS.
- Patients told us that, if necessary, they would not hesitate to raise a concern.
- The trust reported that PALS interventions included re-arranging appointments to meet patient requests and providing contact details.
- We were told that all formal and informal complaints were handled in line with the trust complaints policy.

Are outpatient and diagnostic imaging services well-led?

Requires improvement 

Systems and processes were in place to enable mangers to monitor and influence the work of their staff in their various departments. However we noted that the level of cancelled clinics at around 21% to 23% was not listed on the trust risk register and found no action plan to improve the situation.

Outpatients and diagnostic imaging

There is an overall senior manager of the both the outpatients and diagnostic imaging department services. However, only the outpatients department had its own service lead.

Some of the staff we spoke with were not able to tell us what the trust vision or objectives were. .There were staff meetings for discussing issues and concerns in the department, and there was evidence of shared learning. Staff generally felt listened to and well supported by their managers.

Staff in diagnostic imaging stated that they were well supported by their managers. Staff and managers told us there was an open culture in the department and could approach the managers at any time.

Vision and strategy for this service

- There was a leadership structure for the hospital and staff understood the structure, who their line managers' were and who they reported to in the leadership structure.
- Some of the staff we spoke with were not able to tell us what the trust vision or objectives are. However, their managers were able to tell us what the trust vision, values and strategy are and how they are implemented.

Governance, risk management and quality measurement

- Staff we spoke with reported that regular governance meetings (clinical effectiveness committee and clinical excellence committee) took place to discuss quality initiative programmes in their departments. The minutes of these meetings confirmed this was the case.
- Staff also told us that feedback was given to staff who did not attend via staff meetings and emails. Staff used these meetings to discuss complaints, incidents and quality improvement programmes.
- Incidents were monitored and analysed to inform service improvement.
- Risk registers were in place for both outpatients and diagnostic imaging department. These had controls and assurance in place to mitigate risk and they were reviewed regularly at departmental meetings.
- Patient appointment systems were managed by the service lead in an attempt to reduce waiting times and cancelled clinics. We saw evidence of the trust managers working closely with their CCG colleagues to manage patient appointment systems to reduce waiting times and cancellations.
- Outpatient clinic cancellations amounted to an average 11% of total clinics and clinics cancelled or postponed by the trust was between 10% and 12% over a 3 month period March to June 2014. Together this amounted to cancellations of between 21% and 23% of the total outpatient clinics. We looked to see if this was listed on any of the division or trust risk registers and could not find it. We could also not locate any trust action plan to improve this situation.

Leadership of service

- All staff we spoke with told us their immediate line managers were approachable. Senior managers we spoke with told us they had an open door policy and any member of staff could see them at any time to discuss issues affecting them.
- Staff in outpatients' teams and those from the imaging and diagnostics department regularly attended staff meetings. We saw attendance record and minutes of these meetings, which showed active participation of staff who attended these meetings.
- There was a leadership structure for the department and staff understood the structure, who their line manager was and who they reported to in the structure.
- We saw evidence of managers working closely with staff to manage waiting times, delayed and cancelled clinics.

Culture within the service

- Staff spoke positively about the service they provided for patients. Quality and patient experience was seen as a priority for the department and it was everyone's responsibility.
- The staff we spoke with reported a culture of openness and transparency. Staff were clear when they were performing well, but also fully aware of areas for improvement such as waiting times, delayed and cancelled clinics.
- When we spoke with staff they were able to explain what the key risks were in their department and how this fitted with the current risk profile of the trust.

Public and staff engagement

- There were governance arrangements in place and we noted that complaints and comments were discussed at governance meetings.

Outpatients and diagnostic imaging

- We requested results of patient satisfaction surveys carried out at the outpatients and diagnostic imaging department. However, these were not available, and most of the staff we spoke with were not aware that any such survey been undertaken by their department.
- The trust has a patient experience committee where feedback was discussed to ensure services were monitored.

Innovation, improvement and sustainability

- The outpatients department had expanded and opened a new clinic (outpatients department 8) for older people's care and other services.
- We were told the trust invested in the latest technology and used innovative ways of working to improve the patient and staff experience through the use of self check-in services.
- The trust had a text message reminder service. This informed patients of their appointment time with a request for them to call the hospital if they were unable to make. The hospital would then re-allocate the appointment, and book a new appointment for that patient immediately while they were on the phone.

Outstanding practice and areas for improvement

Outstanding practice

- The A&E department had a calm and well-managed response to very heavy emergency demand on the Wednesday evening of our inspection visit. Management support was also well considered, calm and effective.
- We found the care and support given by the mortuary staff and patient affairs office to relatives after the death of their family member was exemplary.
- The innovative 'heads-up' structured approach to handover in medicine

Areas for improvement

Action the hospital MUST take to improve

Importantly, the trust must:

- Address the midwife/mother ratio both in terms of immediate levels of care and the strategic planning for expansion of obstetric services.
- Review and act upon consultant and nursing staffing levels in Emergency Services
- Review the processes for the management of policies and procedures to ensure that staff has access to the most up to date versions.
- Review its provision of End of Life services; its palliative care staffing levels and support of end of life care on the wards.
- Ensure full completion of DNACPR forms
- In medicine, address the lack of an acute oncology service
- In surgery, improve the frequency of consultant ward rounds.
- Ensure full completion of WHO Checklists for surgery
- Remove the practice of unverified consultant patient discharge letters
- Improve leadership and effectiveness in the SBCU
- Address the issue of late availability of TTA medicines leading to late discharge or patients returning to collect them.

Action the hospital SHOULD take to improve

- Further develop it's strategies for ensuring that the organisation is learning from incidents and issues.
- Continue to clarify its strategic intent, stabilise leadership and continue to engage its workforce in planning for change.
- Review its pharmacy services to be more responsive to the needs of patients
- The trust should ensure that the room in the A&E department designated for the interview of patients presenting with mental ill health has a suitable design and layout to minimise the risk of avoidable harm and promote the safety of people using it.
- The trust should review the arrangements for monitoring patients in the A&E department to ensure clear protocols are consistently used so that changes in patients' condition are detected in a timely way to promote their health.
- The trust should review the number and skill mix of nurses on duty in the A&E department to reflect Royal College of Nursing Baseline Emergency Staffing Tool (BEST) recommendations to ensure patients' welfare and safety are promoted and their individual needs are met.
- The trust should review the number of consultant EM doctors employed in the A&E to reflect the College of Emergency Medicine (CEM) recommendations.
- The trust should respond to the outcome of their own and CEM audits to improve outcomes for patients using the service.
- The trust should review the arrangements for monitoring pain experienced by patients in the A&E to make sure people have effective pain relief.
- The trust should review the arrangements forproviding people with food and drink and assessing their risk of poor nutrition so people's nutrition and hydration needs are met.
- The trust should review their arrangements for assessing and recording the mental capacity of patients in the A&E to demonstrate that care and treatment is delivered in patients' best interests.

Outstanding practice and areas for improvement

- The trust shouldmake arrangements to ensure contracted security staff have appropriate knowledge and skills to safely work with vulnerable patients with a range of physical and mental ill health needs.
- The trust should review some areas of the environment in A&E with regard to the lack of visibility of patients in the waiting area and arrangements for supporting people's privacy at the reception, the observation ward and the resuscitation area.
- The trust should review the provision of written information to other languages and formats so that it is accessible to people with language or other communication difficulties.
- The trust should review the way it considers the needs of people living with dementia when they are in the A&E department.
- The trust should review their management of patient flow in the A&E so patients are discharged in a timely way or transferred to areas treating their speciality.
- The trust should review the risk register in the A&E to make sure all identified risks are included and action is taken to mitigate.
- The trust should review the culture of the A&E to explore the reasons for low morale and reported conflict amongst some staff.
- Improve surgery theatre use to prevent late starts and theatre overruns.
- Review the surgical pathway for children and adults.
- Review physiotherapy at weekends for all patients not just those on enhanced recovery programmes to assist rehabilitation.
- Increase weekend consultant ward rounds in surgery and include Sunday.
- Ensure sufficient beds on surgical wards to improve treatment of surgical patients in specialty beds.
- Improve cleanliness and hygiene in the Special Care Baby Unit (SBCU).
- Formalise multidisciplinary approach to care on the SBCU.
- Share the outcome and learning from audits to staff on the SBCU.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

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

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **In order to safeguard the health, safety and welfare of service users, the registered person must take appopriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experienced persons employed for the purposes of carrying on the regulated activity.** • The provider did not have suitable arrangements to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced nursing staff were employed. • There were insufficient numbers of nurses on duty in A&E given the severiy of patients' symptoms and the geographical layout of the department. • The A&E department did not meet RCN BEST recommendations of a nurse patient ratio of 1:1 in resuscitation (high dependency) and 1:2 in majors (moderate dependency). We observed several occasions in resuscitation when the nurse patient ratio was greater than 1:1. • Regulation 22 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010.

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing **·Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Staffing: In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps**

Requirement notices

to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experience persons employed for the purposes of carrying on the regulated activity.

·The provider did not have suitable arrangements to ensure that, at all times, sufficient numbers of suitably qualified, skilled and experienced medical staff were employed

·The trust did not meet College of Emergency Medicine recommendation that an A&E department should have enough consultants to provide cover 16 hours per day, 7 days per week.

·Of A&E medical staff, 12% were consultants compared with the national average figure of 23%.

Regulation 22 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010

Regulated activity	Regulation
Treatment of disease, disorder or injury	Regulation 22 HSCA 2008 (Regulated Activities) Regulations 2010 Staffing Regulation 22 Health and Social Care Act 2008 (Regulated Activities) Regulations 2010: Staffing: In order to safeguard the health, safety and welfare of service users, the registered person must take appropriate steps to ensure that, at all times, there are sufficient numbers of suitably qualified, skilled and experience persons employed for the purposes of carrying on the regulated activity. ·The provider did not have suitable arrangements to ensure that at all times, sufficient numbers of suitably qualified, skilled and experienced midwives and maternity assistants were employed. ·The Birthrate Plus audit showed a shortfall of 17.6 whole time equivalent (WTE) midwives, and nine WTE too few maternity assistants.

This section is primarily information for the provider

Requirement notices

·The maternity dashboard for the year to October 2014 showed the average number of maternity inpatients per midwife had been 36 from March 2014 compared with the national average of 29.

Regulation 22 (1) (a) Health and Social Care Act 2008 (Regulated Activities) Regulations 2010