London North West University Healthcare NHS Trust

Inspection report

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Date of inspection visit: 9, 10 and 11 February 2022
and 8 and 9 March 2022
Date of publication: 20/05/2022

Ratings

Overall trust quality rating	Requires Improvement
Are services safe?	**Requires Improvement**
Are services effective?	**Requires Improvement**
Are services caring?	**Good**
Are services responsive?	**Requires Improvement**
Are services well-led?	**Requires Improvement**

Our findings

Our reports

We plan our next inspections based on everything we know about services, including whether they appear to be getting better or worse. Each report explains the reason for the inspection.

This report describes our judgement of the quality of care provided by this trust. We based it on a combination of what we found when we inspected and other information available to us. It included information given to us from people who use the service, the public and other organisations.

We rated well-led (leadership) from our inspection of trust management, taking into account what we found about leadership in individual services. We rated other key questions by combining the service ratings and using our professional judgement.

Overall summary

What we found

Overall trust

London North West University Healthcare NHS Trust runs Northwick Park Hospital, Ealing Hospital, Central Middlesex Hospital, St. Mark's Hospital, and a range of community services across its local boroughs.

The trust employs more than 9,000 clinical and support staff and serves a diverse population of approximately one million people. The trust was last inspected in 2019 and was rated requires improvement overall.

The trust provides, urgent and emergency care, medical care, surgery, critical care, maternity, gynaecology, children and young people services, end of life care and outpatient services. The trust provides a range of community services including: dental services, sexual health services, paediatric audiology, musculoskeletal specialist and end of life care.

We inspected medical care and surgery core services at Northwick Park Hospital and Ealing Hospital on 9, 10 and 11 February 2022. Our inspection was unannounced to enable us to observe routine activity. Before the inspection we reviewed information we had about the trust based on the intelligence we had received.

We also carried out an announced well led inspection of the trust on 8 and 9 March 2022. We rated the trust overall requires improvement for well led.

We issued requirement notices to the trust for medical care at Ealing Hospital. Details of these can be found under the Musts in the Areas for Improvement section.

We rated medical care at Ealing Hospital requires improvement overall because:

- The service did not always have enough nursing and support staff to keep patients safe. The service was mitigating the staffing risks during twice daily safety huddles. However, there was a 22% vacancy rate for band 5 nurses.

Our findings

- We found a drawer in the catheterization labs with a range of out of date equipment and a monitor in the catheterization labs which did not have a servicing date. We also found out of date equipment on a resuscitation trolley in the acute medical unit (AMU). There was a risk that staff could inadvertently use out of date equipment.
- On Ward 6 South, we found discrepancies in the use of Waterlow scoring. This is a tool used for pressure area risk assessment. This meant that patients' level of risk of developing pressure ulcers may not be accurately assessed and timely actions taken.
- Medical staff mandatory training in resuscitation was 72.2%. This was less than the 80% standard. This meant some staff may not have up to date skills in resuscitation.
- There was a lack of seamless services between the trust and other NHS providers of mental health care for patients temporarily on an acute ward waiting for transfer to a mental health facility. There was a risk of delays in patients care and treatment as a result of a lack of clarity about the responsibility for clinical decision making whilst the patient was an inpatient in the acute hospital.
- Due to a shortage of registered mental health nurses, the service had a policy of cohorting patients assessed as requiring enhanced observations or one to one care in a bay. However, we saw cohorted bays were not always observed by staff. There was a risk to patients if they were assessed as requiring enhanced observations or one to one care and this was not provided in accordance with their assessed needs at all times.
- The patient electronic record could only display a maximum of two patient needs on screen. This had led to staff not placing a magnetic identifier for the confusion care pathway above a patient's bed. The lack of a visual prompt for staff led to a patient not receiving a scheduled review after 72 hours. There was a risk that without a visual prompt, staff working on the bay may not be aware of patients' needs, unless they fully consulted patients' electronic records.
- Records were not always stored securely. We found a patient's 'adult inpatient care needs assessment' booklet next to the reception area in the acute medical unit (AMU). We saw a computer in the endoscopy reception which was unattended and not locked. There was a risk that unauthorised people could have accessed confidential patient information.
- Staff told us the trust's senior executive team and some ward leaders were not visible at Ealing Hospital, as they were based off-site at Northwick Park Hospital.
- The signage enabling patients and visitors to navigate around the hospital was confusing for patients and visitors.
- Staff on the Older Persons Short Stay Unit (OPSSU) were using a printed copy of the infection prevention and control policy. There was a risk that staff may use an out of date policy instead of using the most up to date policies on the trust's intranet.
- We saw a cracked shower chair and shower chairs with chipped enamel on the OPPSSU. This could pose a patient safety and infection control risk as microorganisms can thrive in cracked surfaces.
- Domestic staff on the acute medical unit (AMU) was not aware of control of substances hazardous to health regulations (COSHH), including the trust's policies and guidance on COSHH.
- The trust was a large provider of cancer services but staff told us they did not have a local cancer strategy. This meant there was a potential risk that cancer services were not aligned to local commissioning and provision of services to support people during and after their cancer treatment.

However:

- The service managed safety incidents well and lessons were learnt from them.
- Staff gave patients enough to eat and drink and gave them pain relief when they needed it.

Our findings

- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to information.
- Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to raise complaints.
- Staff understood the service's vision and values, and how to apply them in their work and all staff were committed to improving services continually.

We rated surgery at Ealing Hospital good overall because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service was not fully compliant with DHSC Health Technical Memorandum 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste.
- The service had persistently high vacancy rates. At the time of our inspection the service had vacancies for 36 whole time equivalent (WTE) nurses (12%). However, the number of nurses and healthcare assistants matched the planned numbers and vacancies were filled with bank and agency staff.

We rated medical care at Northwick Park Hospital requires improvement overall because:

Our findings

- Indications of patients having venous thromboembolism (VTE) prophylaxis were not always specified on the prescription charts we viewed. This meant staff reading the prescription may not have information on patients VTE status.
- Records were not always stored securely. We saw records cupboards were not locked when not in use on Darwin ward. This meant unauthorised people may have been able to access patients' confidential information.
- All staff did not consistently receive feedback from incidents. One member of staff on Darwin ward told us they were not aware of an incident that had happened on the ward.
- We saw a 'do not attempt cardiovascular resuscitation' (DNAR) form on Herrick ward where it was unclear whether the patient's DNAR had been cancelled. Staff were unable to tell us the reasons for the cancellation.
- We saw a sharps bin in the discharge lounge stacked on top of another sharps bin. The sharps bin was open and had not been signed or dated. There was a risk of the sharps bin being knocked over and potentially causing harm to patients or staff.
- We saw a wheelchair with broken foot straps on the discharge lounge. There was a risk that staff may have used the wheelchair, even though staff had reported the wheelchair to the medical engineering department.
- The hospital was not meeting national standards in some areas of the myocardial ischaemia audit.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

We rated surgery at Northwick Park Hospital good overall because :

- The service managed staffing well and maintained consistent levels of training and appraisals despite pressures on the service caused by COVID-19.
- Services were demonstrably multidisciplinary, and staff had established a wide range of new working opportunities to support patient outcomes.

Our findings

- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Pharmacy cover on wards was limited due to short staffing. This meant pharmacists could not always join ward rounds and could not always review prescriptions daily.
- The service did not have a coherent, overarching vision for what it wanted to achieve. Individual departments and divisions developed their own strategies in the absence of a trust-level approach.

We carried out a well led inspection of the trust on 8 and 9 March 2022.

We rated well led for the trust as requires improvement overall because:

- We found that issues such as lack of adequate mental health provision for patients in crisis were a regular feature although the trust recognised the need to urgently address this issue.
- The trust Board was not representative of the population it served. However, we noted the trust had developed equality, diversity and inclusion strategies.
- The current trust strategy was in need of refreshing and updating to demonstrate more clearly its purpose within the integrated care system. The new chief executive recognised the need to renew the strategy linking clinical, finance, workforce, community and estates strategies.
- Despite a strengthened governance structure, the trust governance team was under-resourced, leading to late and incomplete information both externally and internally to the board.
- Further work was needed on the trust board assurance framework to ensure that actions were specific, measurable, actionable, relevant and timely (SMART).

However:

- The executive board and non-executives had developed in cohesiveness and visibility with a strong emphasis on improvements in performance and embeddedness.
- We noted improved clinical leadership and a greater involvement of the medical workforce in the ongoing work of the trust.

Outstanding practice

We found the following outstanding practice in medical care at Ealing Hospital:

- Cancer services maintained its chemotherapy services throughout the COVID-19 pandemic.

Our findings

We found the following outstanding practice in surgery at Ealing Hospital:

- The allied health professional team had significantly improved capacity for effective cross-site, multidisciplinary working through a 'beyond professional boundaries' programme. This meant staff were upskilled in new areas and enabled outpatient and inpatient teams to work together more responsively to improve patient outcomes.
- A multidisciplinary team of tissue viability nurses, cancer nurses, and physiotherapists had secured funding for an innovative 'prehabilitation' programme. This enabled them to work with colorectal surgery patients prior to surgery to established comprehensive post-operative care planning that would improve outcomes.

Areas for improvement

MUSTS

Ealing Hospital Medical Care:

- The trust must ensure patient records are always stored securely and cannot be accessed by unauthorised people.
- The trust must ensure all equipment is serviced in accordance with manufacturers' instructions and the trust's policies.
- The trust should ensure cracked and broken equipment on the older persons short-stay unit equipment is removed and replaced.

SHOULDS

Ealing Hospital Medical Care:

- The trust should ensure that there are enough nursing and support staff on every shift to keep patients safe.
- The trust should ensure Waterlow scoring is accurate to keep patients safe from the risk of developing pressure ulcers.
- The trust should work with system partners to ensure there is a seamless service and clarity about clinical decision making in the provision of care at the trust and other NHS providers of mental health care.
- The trust should ensure patients assessed as requiring enhanced observations or one to one care receive care in accordance with their assessed needs at all times.
- The trust should ensure magnetic identifiers above patients' beds reflect all the patients' identified needs as recorded on their patient record.
- The trust should ensure the trust's senior executive team and ward leaders are visible to staff and patients at Ealing Hospital.
- The trust should ensure the signage that enables patients and visitors to navigate around the hospital is clear to patients and visitors.
- The trust should ensure staff use up to date policies on the trust intranet.
- The trust should ensure staff required to use control of substances hazardous to health (COSHH) products, are aware of the trust's policies and guidance on COSHH.

Our findings

- The trust should consider a local cancer strategy, to ensure cancer services are aligned to local commissioning and provision of services to support people during and after their cancer treatment.

Northwick Park Hospital Medical Care:

- The trust should ensure that patients' venous thromboembolism (VTE) risk is always specified on the prescription charts, to ensure all staff have information on patients VTE status.
- The trust should ensure records are always stored securely, to ensure unauthorised people cannot access patients' confidential information.
- The trust should ensure 'do not attempt cardiovascular resuscitation' (DNAR) are recorded clearly to ensure staff know if the form has been cancelled.
- The trust should ensure sharps bins are stored securely, sealed, signed and dated.
- The trust should ensure broken equipment is removed from the wards in a timely way and signage is used to indicate if equipment is broken and should not be used.
- The trust should ensure all staff consistently receive feedback from incidents across the medicines division.
- The trust should ensure all staff receive feedback from incidents.
- The trust should consider a cancer strategy which focuses on local priorities.

Northwick Park Hospital Surgery:

- The trust should ensure that staff in the theatre assessment unit have an equitable level of support as their colleagues across the core service.

Is this organisation well-led?

Our rating of well led stayed the same. We rated it as requires improvement.

Leadership

The outgoing chief executive had been interim and in post since March 2020 and had steered the trust through the period of the COVID-19 pandemic. The new incoming chief executive had been in post for four weeks at the time of our inspection and was already familiar with the trust through their previous role. The trust board and senior leadership had had a period of stability as a corporate body and were skilled and knowledgeable. They had worked together to build a cohesive leadership team. Changes to that team were imminent but reasons for leaving were for future career development and replacements had been recruited. Leaders were sighted on risks at service and corporate level.

The quality and performance metrics of frontline services had improved since our last inspection in 2019. These included improvements in the performance of the Urgent and Emergency Department at Northwick Park Hospital; improved performance for length of stay of patients; and improved cancer treatment, diagnostics and elective recovery performance.

Our findings

The trust had eight executive members and ten non-executive directors (NEDs) on the board including the chair and two associate NEDs. The board was not diverse. In a bid to address this, three associate NEDs were recruited from black Asian and ethnic minority (BAME) backgrounds. One of the existing associate NEDs had since been appointed to a NED vacancy.

There were six committees, each chaired by a NED, reporting to the board. These were: audit, workforce, quality, finance, charitable funds and appointments committees. Also reporting to the board was the trust executive management group chaired by the chief executive. This was supported by twelve reporting groups relating to operational performance, strategy and transformation.

The board of directors were open and honest about the challenges the trust faced. They described themselves as on a continuing journey to improvement but at the same time they were proud of what the trust had achieved particularly during the COVID-19 pandemic. Due to the effects of the pandemic within the local population, the trust had faced early and severe pressures and it was felt that the pandemic had in fact empowered and accelerated a greater sense of teamworking and common purpose.

We interviewed the Non-Executive Directors as part of their individual roles as chairs of committees and also as a group. We found them to be fully engaged and active in the trust. They worked cohesively and presented a positive challenge to the executive and were a mix of relatively new and experienced members. While the pandemic had lessened their physical ability to visit in person to assess governance, they had continued weekly on-line meetings with the chair and there had been a greater reliance on informal networks to maintain a level of assurance which might not have been as rigorous as face to face. However, this had not lessened their overall involvement and they said that they had built strong relations with executive colleagues particularly in relation to audit and finance.

The trust Fit and Proper Persons Policy (FPPR) was issued in October 2021. During the inspection we reviewed the personnel files of ten members of the board. All files were in line with the requirements of the fit and proper persons regulation and policy with the exception of two annual FPPR declarations which were out of date, and one NED who had a standard DBS check requiring an enhanced check.

The trust had six divisional directorates which were headed by a triumvirate of divisional director of nursing, operations director and clinical director. This triumvirate structure was replicated one level below in the leadership structure. Both upper tiers worked across the three main sites of the trust. This was described as a challenge but had been aided by greater and often daily virtual operational meetings which the pandemic had made necessary. The new CEO stated that it was the intention to put in place a senior site nursing, operational and clinical team at each location as soon as possible and some appointments had already been made.

There were nominated leads for learning disabilities, Mental Capacity Act, Mental Health Act and child and adolescent mental health. There were also trust leads for safeguarding children and adults. The chief nurse was the director of infection prevention and control (DiPC), assisted by a deputy DiPC. There were nominated sponsor NEDs for areas such as Freedom to Speak up Guardians and individual equality and diversity networks.

We noted stronger clinical leadership and more medical team involvement with the trust compared with the last inspection. We were given examples of clinicians' involvement with the trust and supporting trust and divisional objectives. We interviewed the guardian of safe working hours who was content with the level of trust support and reported no undue issues. We looked at arrangements for business continuity and emergency planning and the team had in place robust measures to meet any contingency and demonstrated that they were closely involved with emergency agencies in terms of preparation and ongoing training.

Our findings

Succession planning was in place and where leaders had left the trust , early planning was in place to ensure recruitment without delay. Two recent examples of this were the appointment of deputy chief operating officer to chief operating officer and deputy medical director to medical director.

Since our last inspection when we had noted a lack of a cohesive board development programme, a programme was now in place with external providers emphasising development of board maturity, risk, equality diversity and inclusion and leadership.

The trust had a stated planned turnover of £830 million for the financial year 2021-2022, and planned to spend approximately £50 million funding to improve its estate, equipment and digital infrastructure. The trust had an underlying deficit of approximately £80 million and in line with other trusts had received cash support from NHS England during the COVID-19 pandemic. The trust was working with the North West London integrated Care System (ICS) to address the deficit which also consisted of a PFI component for Central Middlesex Hospital. The trust expected to achieve £30 million savings in 2022-2023 with an additional support of £20 million from the ICS and manage £30 million of income pressures. At the time of our inspection the trust board was still to approve this three year financial recovery plan to close the budget gap.

The Chief Pharmacist had professional accountability to the Medical Director. Whilst new in post, they had utilised the already well-established links with the Medical Director, Chief Nurse and the board to ensure visibility of medicines issues. The drugs and therapeutics committee meetings were well attended and had appropriate challenge of medicines related decisions taking place. The Chief Pharmacist had succession plans to manage staffing changes in the pharmacy department. Plans were in place to ensure involvement at ICS level to implement sharing of specialist knowledge.

Vision and Strategy

The trust recognised the need to refresh its strategy and there were still issues around the clarity of its strategy.

At the last trust inspection in 2019, we noted a lack of strategy in place following the non-continuation of Shaping a Healthier Future. Since then they had produced “The Way Forward” strategy document. It was now recognised that the trust strategy needed to be refreshed in the light of further ICS integration. In our core service inspection in February 2022, staff appeared to be clearer about the strategy within their own division but less clear about the overall trust strategy.

Following the COVID-19 pandemic the trust aligned with new ICS and national ways of working particularly in addressing the patient waiting backlog that had developed. At the same time remaining community services were transferred to other NHS providers. The trust also developed a workplan to rebuild services “better than normal”, learning from the pandemic experience.

The trust’s vision was to provide excellent clinical care in the right setting; to provide excellent care, quality and patient experience; to engage with staff to develop them and transform our services, and to become a sustainable organisation that builds partnerships with purpose.

There was a sense of ownership of the local constituent hospitals within the trust by both local population and staff particularly at Ealing and Northwick Park. Ealing staff still felt anxious and uncertain about the future of Ealing hospital.

It was expected that the updated strategy would be produced around September-October 2022. During the pandemic, the trust had taken steps to remove patient pressure from the Northwick Park site by transferring St Mark's specialist

services and “green” elective surgery to Central Middlesex Hospital. However, it was not clear if this was to be a permanent move requiring formal consultation and ICS approval. The trust strategy would need to concentrate on the long term opportunities as opposed to short term transfers of services and linking finance, clinical, workforce, integration, community and estates strategies.

The medicines optimisation strategy was in place prior to the new chief pharmacist joining the trust. In future, joint work with the ICS will be crucial to admissions avoidance. We found ongoing medicines workstreams on genomics, antimicrobial stewardship and COVID-19 recovery plans. There was a business case to build a new aseptic unit to increase the trust’s production capacity and medicines administration system in the trust.

Key themes and aims from the trust transformation programme were better care for patients, better experiences for staff and better use of resources. Larger strategic work across the trust: Central Middlesex Hospital and access and flow programme. Projects included Maternity, Emergency Department, agile working and working with corporate teams.

Culture

Since the merger of the former trusts into one in the early 2010s, the trust has been on a cultural journey. In the early days there was a lack of cohesiveness between the sites and component parts of the trust. The culture of the trust at this inspection was more cohesive and aided by technology to promote greater communication. The interim chief executive emphasised well-being in the light of the pressures of the pandemic on staff and patients.

The leadership team displayed an open and honest culture and modelled positive behaviour and relationships. During our core service inspection, we spoke with a number of corporate and clinical staff who told us that overall, the culture of the trust was improving and that there was a determination and enthusiasm amongst the majority of staff to embed improvements not only in performance but in trust culture. The trust executives described that future board meetings will be held across the three main sites. The Chief Pharmacist made it a priority to engage with small groups of pharmacy staff to encourage discussion and ensure visibility. They were committed to improving the culture surrounding the reporting of medicines incidents across the trust. The education and training lead worked with the pharmacy team to ensure that appraisals were of quality and linked to the strategy.

The trust was reinforcing its behavioural and trust HEART values, which encompass honesty, equality, accountability, responsibility and teamwork. This included refreshing and reinforcing the behavioural framework to further embed these values which had been established some time ago and still met trust and employee needs.

We noted a change to positive workforce culture within the maternity department brought about by the newly appointed director of midwifery who had set the example of leadership through visibility and listening to staff. This had been mirrored further down the leadership chain to positive result. Having focused on improving the culture there was still work to do on patient care, quality and operational efficiency.

In terms of diversity, 75 per cent of trust employees were women; 65% were from BAME backgrounds; 2% of staff disclosed that they consider themselves to have a disability, and 2% of staff declared their sexual orientation as lesbian, gay, bisexual, transgender, queer and intersex (LGBTQI). We spoke with members of support networks. The BAME group and Disability group representatives told us that they had received support from the trust and from their executive sponsor. The LBTQI representative felt equally supported and said that the group was currently reforming following the pandemic.

Our findings

As part of its transformation and equality diversity and inclusion programme the trust was taking positive action initiatives including an initiative for staff in nursing bands 2-7 called Progress 2-7 aimed at their development and progression. There was also a Progress Plus 8 programme open only to staff from a BAME background which involved secondment of Band 7 staff into Band 8 for a year. There was also a leadership programme in other organisations. Two BAME staff were currently on this programme.

In the latest NHS Staff survey benchmarking summary of the trust's results compared with trusts of equal size and complexity the trust scores were around average for 18 themes; below average for 28 themes including those for bullying and harassment.

61.2% of 4643 staff took part in the trust's 2021 staff survey which was the highest participation rate to date compared to 53.2% in 2020 and the national average of 46%. In relation to the question: Does your organisation act fairly with regard to career progression / promotion, regardless of ethnic background, gender, religion, sexual orientation, disability or age? 48% of staff answered yes compared to 46.6% in 2020. 81.6% of staff said they had received an appraisal, annual review, development review, or Knowledge and Skills Framework (KSF) development review in the last 12 months. This was an increase from 79.6% in 2020. The percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months was 27.8% for BAME staff in 2021 which was a decrease from 30.5% in 2020. It was 29% for white staff in 2021 which was a decrease from 30% in 2020. The percentage of staff who felt the trust provided equal opportunities for career progression or promotion was 46.4% for BAME staff in 2021. This was an increase from 43.6% in 2020. It was 55.4% for white staff in 2021 which was a slight increase from 55.3% in 2020. In the 2021 staff survey, 57% of staff told said that the trust took positive action on health and wellbeing. This was a significant improvement from 28% in the 2020 survey.55.5% of staff recommended the trust as a place to work; this had decreased from 59.2% in 2020. 58.8% of staff recommended the trust as a place to receive care; this had decreased from 63% in 2020. 48.4% of staff felt they got recognition for good work. This was a decrease from 53.9% in 2020.

The trust said that staffing workload and recognition will be key areas for action this year from the results of the survey.

Since our last inspection in 2019 the number of Freedom to Speak up Guardians has increased from two to five with the appointment of eight Freedom to Speak up Champions to support them. The Guardians we spoke with were content with the support given to them and they felt more part of a network with Guardians from other trusts.

We spoke with representatives from unions and staff associations. They told us that while they had given every support to the trust during the pandemic, they often felt that communication with them could be improved. For example, they said that they often found out about developments in the ICS from representatives at other trusts before any communication from the trust. They also expressed frustration that at the formal JNCC meetings, some senior trust representatives were regularly absent which meant that their questions could not be answered at the meeting but had to be taken away and referred elsewhere leading to delay. They did however praise the finance leadership who were regular JNCC attenders and were able to answer their questions. They hoped that this good example could be followed by others within the trust.

The trust's underlying sickness absence levels from December 2020 to November 2021 were below the England average but has steadily increased since. In November 2021 the sickness rate was 3.7%, the highest reported for total staff at this trust compared to the England average of 4.8%. These figures excluded absences due to COVID-19.

Governance

Our findings

The trust had governance structures, systems and processes in place to support performance. However, the governance team was under resourced and this had led to a backlog of governance information both internally and externally and meant that issues were not identified quickly causing a lack of board and external prompt awareness.

The governance structure was based on the trust board, executive and division supported in a matrix model by a triumvirate of clinical operations. Key leadership responsibilities were held by the chief medical Officer, chief nursing officer and chief operating officer. There were parallel site designated or divisional roles for medical, nursing and operations.

The governance reporting structure to the board was through seven sub board committees namely audit, workforce and equality, quality and safety, finance and performance, charitable funds and appointments and remuneration. Each committee was chaired by a non-executive director with the appropriate skills and knowledge.

In addition, a trust executive management group (TEG) had been set up, chaired by the chief executive. This was made up of executive directors and attended by executive members of staff as required. There were seven performance groups and five strategic and transformation groups reporting directly to the TEG which in turn reported to the board. Papers for the trust board could be submitted via TEG or via the various sub board committees. In practice most went to the relevant committee as well as the TEG.

There were effective governance structures for managing medicines optimisation within the trust. The Chief Pharmacist recently met with the Controlled Drugs liaison officer from the Metropolitan Police to seek assurance on the governance processes for controlled drugs in the trust. Pharmacy staff were involved in the provision of medicines related training in the trust. There was also a monthly medicines newsletter for staff.

CQC found a delay in obtaining governance information from the trust. For example, there was a backlog of serious incident information from the trust which CQC is required to review. CQC came across information such as the trust's own commissioning of an external review into the series of perinatal deaths which had occurred in 2020. From review of this information it was clear that had the trust's governance system picked up the high number of missed appointments and scans in ante natal care for various reasons but mainly due to lack of adequate translation services and lack of joined up ante natal care, the outcome might have been different in some cases.

The trust had reported an increased number of patients with mental health issues attending urgent and emergency care. The trust declared 23 twelve hour breaches of mental health patients overstaying in acute facilities in February 2022. We were told that this was such a regular occurrence and had been for some time that it was the norm. The trust was aware of the problem and the new chief executive said that a meeting with the neighbouring mental health trusts was being convened to try to achieve a solution.

We identified examples where, via the investigatory regulatory process, the trust initially had identified one person affected within a patient cohort, this later transpired to impact four patients. This demonstrates a lack of oversight, assurance and timely identification in order for the trust to identify lessons and improve.

Management of risks, issues, and performance

In our 2019 inspection report, we noted that the Board Assurance Framework (BAF) as an assurance framework still needed further development. There needed to be more detail with greater identification of accountable personnel and a greater link defined to the risk register. Since then, with a trust executive group and strengthened committee structure, we saw that the BAF and corporate risk register were considered by all committees and deep dives were undertaken as

part of routine committee business. A review of both documents showed that the analysis of risks, and gaps in controls and assurance, were well defined and considered. However, the actions required were not SMART (specific, measurable, actionable, relevant, timely), and therefore could not provide assurance that risks were being appropriately mitigated in a timely manner. As an example, the Women's and Children's division had 29 open risks of which 26 were recognised as being of significant and one of high risk. One risk had been closed between November 2021 and January 2022 . The inspection team were concerned that the governance arrangements were more focussed on re-assurance than assurance.

The work of the Audit committee was focussed on assurance; and processes of triangulation of assurance and deep dives into risks were described to us by the chair; there was a structured review of risk by the trust's executive that informed the review of the board assurance and corporate risk register. Relationships with internal and external auditors were described as positive; and the internal auditors had given assurance annually on the operation of systems of internal control.

The Finance committee believed that it was well-sighted on the financial position of the Trust and the wider context of the NW London system deficit. It had reviewed internal efficiency opportunities taking into account benchmarking data and internal initiatives for transformation. It had noted that the national "model hospital" top-down view indicated efficiency opportunities of c£30million, and drew to the inspection team's attention the work that was beginning to take place through patient level costing on excess costs. It also recognised that delivery would be impacted by the capacity and capability of teams to drive change. However, the inspection team noted that, despite these reassurances, at the time of the inspection the Committee had not received details of the CIP and transformation programmes to provide assurance of financial delivery in 2022-2023.

There were clear lines of communication between the Chief Pharmacist and the Medical Director. The board were sighted on areas of medicines risk which was captured on the medicines risk register. This was reviewed at a monthly risk meeting and added to the trust risk register.

Risk mitigation was in place for managing temperature excursions in areas used for medicines storage. The trust had systems to manage patient safety alerts to ensure that they were actioned with the appropriate clinical input. We were told that there were no specific areas where risks were yet to be mitigated. However, the trust felt that the surgical and paediatric pharmacy team could be enhanced.

Information management

During 2020-2021 the trust appointed a joint chief information officer with a neighbouring trust with a view to greater collaboration. During the same period, improvements were made to the trust website to make it more accessible. There were also improved translation facilities for people with little or no English including automated "check-in" kiosks.

During the twelve month period April 2020 to April 2021 there were three data protection incidents which were reported to the Information Commissioners Office, one of which was referred to the Information Commissioner. No further action was taken on any of the incidents.

When the trust installs a comprehensive electronic patient record system (EPR) in the autumn of 2023, it plans to make records more easily accessible and improve accuracy of recording by removing the need for paper recording and access to different recording systems. The EPR will be the same as the rest of the ICS and include electronic safeguarding records. Until that time the trust needs to maximise the use of its existing information systems to assure the production of speedy and accurate quality, performance and metric information.

Our findings

Information technology was already used to improve the quality of medicines management. For example, use of automated medicines cupboards aids staff in dispensing medicines on most wards. A programme to ensure adoption on all wards was due to be completed imminently.

Staff accessed summary care records from GP surgeries, and sent discharge information to GP surgeries electronically.

Whilst electronic prescribing and medicines administration (EPMA) had not yet been implemented in the trust, this was due to happen within twelve months.

Public, staff, and external partners' involvement

Since the inception of the integrated care system (ICS) for North West London, the trust had participated fully in the integration process which was still in train. The inspection team were told that the North West London health system recognised the wider financial challenge that it had to address; and that the trust were playing a full part in developing sector-wide plans for improving health outcomes whilst returning to financial sustainability. The trust chief finance officer chaired the acute finance directors' forum; and had led initiatives to improve understanding of the financial challenges facing acute services as the sector planned to return to financial sustainability.

The new chief executive stated that there was a clear intention to engage more with the various local communities and stakeholders when developing the trust strategy and that there would be a regular series of meetings to this end.

The trust publicised the media through which patients and public could communicate their views on patient care at the trust. These included: social media platforms; advertised stakeholder events; engagement forums such as Healthwatch; surveys; Friends and Family Test; liaison with Patient Advice and Liaison Service; writing directly to the trust; posting on care opinion websites, and via the medical examiner system.

The trust received 652 complaints between 2020-2022. (The NHS complaints process was put on pause in April 2020, which was then lifted on 1 July 2020. Complaints received during this time were however acknowledged and any issues that could be resolved were responded to).

We reviewed a random selection of ten complaints. Complaints and concerns were taken seriously and responded to in an open and timely way. Investigations were undertaken appropriately and there was evidence of learning. We did not find recorded evidence that complaints were risk assessed, although the trust subsequently stated that they were not asked for evidence, but we were assured verbally that this did occur for all complaints.

The pharmacy team engaged in partnership working to ensure that that services being delivered were of high quality. The Chief Pharmacist regularly met with other Chief Pharmacist colleagues in North West London. The trust attended North West London Integrated Care system meetings and was on the aseptic board. The trust medication safety officer (MSO) was part of the national MSO network.

The trust was linked into the appropriate London network for the sharing of information relating to the use of controlled drugs. It was hoped that the implementation for an electronic prescribing medicines administration (EPMA) system would enable clinical pharmacists to have more time to speak to patients about their medicines. Going forward, there was a plan to engage at Primary Care Network level with non-pharmacy stakeholders.

Learning, continuous improvement and innovation

Our findings

The trust continued to expand its research portfolio for patients and clinicians to take part in research projects including urgent public health and COVID-19 research studies and vaccination trials. The COVID-19 pandemic led to a temporary suspension to the set-up of new studies but the majority of these had since restarted. The trust established a new clinical research facility which also offered treatments and interventions to research participants. In addition to the research and development programme, we noted individual examples of innovation by clinical and ward staff throughout the trust.

The trust continued to expand its research portfolio and increased opportunities for patients and clinicians to take part in high profile research projects including urgent public health and COVID-19 research studies. Research and development also increased its portfolio of service evaluations and quality improvement projects. During 2020-2021, the trust recruited 7,323 patients to 46 clinical research studies. The trust had restarted 80% of research studies suspended during the pandemic. At the end of 2020, a new Clinical Research Facility (CRF) was established . It delivered treatments and interventions to research participants and was equipped with a laboratory, and four treatment bays. It was staffed by on site research pharmacists and clinical staff with research experience

The trust's Patient Research Forum continued to work remotely to support trust researchers and take an active role in advising and reviewing new research ideas from researchers. Patients were also involved in the early stages of research projects via focus groups and feed into protocol development.

Pharmacy leaders were aware of the issues raised during recent CQC inspections. When a medicines incident occurred, actions were taken to prevent reoccurrence. Learning was shared widely across a variety of staff disciplines.

Key to tables

Ratings	Not rated	Inadequate	Requires improvement	Good	Outstanding
Rating change since last inspection	Same	Up one rating	Up two ratings	Down one rating	Down two ratings
Symbol *	→←	↑	↑↑	↓	↓↓

Month Year = Date last rating published

* Where there is no symbol showing how a rating has changed, it means either that:

- we have not inspected this aspect of the service before or
- we have not inspected it this time or
- changes to how we inspect make comparisons with a previous inspection unreliable.

Ratings for the whole trust

Safe	Effective	Caring	Responsive	Well-led	Overall
Requires Improvement →← May 2022	Requires Improvement →← May 2022	Good →← May 2022	Requires Improvement →← May 2022	Requires Improvement →← May 2022	Requires Improvement →← May 2022

The rating for well-led is based on our inspection at trust level, taking into account what we found in individual services. Ratings for other key questions are from combining ratings for services and using our professional judgement.

Rating for acute services/acute trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Northwick Park Hospital	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Good ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022
Central Middlesex Hospital	Good Nov 2019	Good Nov 2019	Good Nov 2019	Requires improvement Nov 2019	Requires improvement Nov 2019	Requires improvement Nov 2019
Ealing Hospital	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Good ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022
Overall trust	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Good ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022

Ratings for the trust are from combining ratings for hospitals. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Rating for Northwick Park Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ➔➔ May 2022	Good ↑ May 2022	Good ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Good ↑ May 2022	Requires Improvement ➔➔ May 2022
Services for children & young people	Requires improvement Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018
Critical care	Requires improvement Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019	Good Mar 2019
End of life care	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Good ➔➔ May 2022	Good ➔➔ May 2022	Good ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Good ➔➔ May 2022	Good ➔➔ May 2022
Urgent and emergency services	Good Nov 2019	Requires improvement Nov 2019	Good Nov 2019	Requires improvement Nov 2019	Good Nov 2019	Requires improvement Nov 2019
Maternity	Requires improvement Dec 2021	Good Dec 2021	Good Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021	Requires improvement Dec 2021
Overall	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Good ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022	Requires Improvement ➔➔ May 2022

Rating for Central Middlesex Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Good Nov 2019	Good Nov 2019	Good Nov 2019	Requires improvement Nov 2019	Requires improvement Nov 2019	Requires improvement Nov 2019
Surgery	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019	Good Nov 2019
Overall	Good Nov 2019	Good Nov 2019	Good Nov 2019	Requires improvement Nov 2019	Requires improvement Nov 2019	Requires improvement Nov 2019

Rating for Ealing Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Medical care (including older people's care)	Requires Improvement ↑ May 2022	Good ↑ May 2022	Good ↑ May 2022	Requires Improvement →← May 2022	Requires Improvement →← May 2022	Requires Improvement →← May 2022
Services for children & young people	Requires improvement Aug 2018	Requires improvement Aug 2018	Good Aug 2018	Good Aug 2018	Requires improvement Aug 2018	Requires improvement Aug 2018
Critical care	Good Jun 2016	Good Jun 2016	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016
End of life care	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Outpatients and diagnostic imaging	Good Jun 2016	Not rated	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Surgery	Good ↑ May 2022	Good ↑ May 2022	Good →← May 2022	Requires Improvement →← May 2022	Good ↑ May 2022	Good ↑ May 2022
Urgent and emergency services	Good Nov 2019	Requires improvement Nov 2019	Good Nov 2019	Requires improvement Nov 2019	Good Nov 2019	Requires improvement Nov 2019
Overall	Requires Improvement →← May 2022	Requires Improvement →← May 2022	Good →← May 2022	Requires Improvement →← May 2022	Requires Improvement →← May 2022	Requires Improvement →← May 2022

Rating for community health services

	Safe	Effective	Caring	Responsive	Well-led	Overall
Community health services for adults	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016
Community end of life care	Good Jun 2016	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community health services for children and young people	Requires improvement Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016	Good Jun 2016
Community health inpatient services	Requires improvement Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018
Community dental services	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018	Good Aug 2018

Overall ratings for community health services are from combining ratings for services. Our decisions on overall ratings take into account the relative size of services. We use our professional judgement to reach fair and balanced ratings.

Northwick Park Hospital

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Harrow
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Description of this hospital

Northwick Park hospital serves an ethnically diverse population mainly concentrated in the London Borough of Harrow. Northwick Park Hospital provides the following services:

•Urgent and emergency care

•Medical care (including older peoples care)

•Surgery

•Maternity and gynaecology

•Outpatients and diagnostics

•Critical care

•End of life care

•Children's and young people services.

We inspected medical care and surgery core services at our inspection on 9, 10 and 11 February 2022.

Medical care at Northwick Park Hospital was last inspected in August 2018 when it was rated requires improvement for safe, effective, responsive and well led and good for caring. Medical care was rated as requires improvement overall.

At this inspection our overall rating of medical care stayed the same. We rated the service overall requires improvement. We rated safe, and responsive as requires improvement and good for effective, caring and well led.

Medical services involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. Medical care at Northwick Park Hospital provided care and treatment in the following disciplines: regional rehab unit; stroke; care of the elderly; cardiology; dermatology; genitourinary medicine (GUM) and sexual health; infectious disease; respiratory; rheumatology; endocrinology and diabetes; neurology and gastroenterology.

Our findings

During this inspection we visited Fielding, Dryden, Crick, Darwin, Haldane, Hardy, Gaskell, Jenner and Fletcher wards. We also visited the discharge lounge and endoscopy. We spoke with 25 staff members and viewed 24 patient records. We also spoke with six patients.

We rated medical care at Northwick Park Hospital requires improvement overall because:

- Indications of patients having venous thromboembolism (VTE) prophylaxis were not always specified on the prescription charts we viewed. This meant staff reading the prescription may not have information on patients VTE status.
- Records were not always stored securely. We saw records cupboards were not locked when not in use on Darwin ward. This meant unauthorised people may have been able to access patients' confidential information.
- All staff did not consistently receive feedback from incidents. One member of staff on Darwin ward told us they were not aware of an incident that had happened on the ward.
- We saw a 'do not attempt cardiovascular resuscitation' (DNAR) form on Herrick ward where it was unclear whether the patient's DNAR had been cancelled. Staff were unable to tell us the reasons for the cancellation.
- We saw a sharps bin in the discharge lounge stacked on top of another sharps bin. The sharps bin was open and had not been signed or dated. There was a risk of the sharps bin being knocked over and potentially causing harm to patients or staff.
- We saw a wheelchair with broken foot straps on the discharge lounge. There was a risk that staff may have used the wheelchair, even though staff had reported the wheelchair to the medical engineering department.
- The hospital was not meeting national standards in some areas of the myocardial ischaemia audit.

However:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service-controlled infection risks well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff understood the service's vision and values, and how to apply them in their work. Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

Our findings

Surgery at Northwick Park Hospital was last inspected in November 2019 when it was rated good in safe, effective, caring and well led and requires improvement in responsive. Surgery was rated as good overall.

At this inspection our overall rating of surgery stayed the same. We rated the service overall as good. We rated safe, effective, caring, and well led as good and responsive as requires improvement.

We visited the following areas during our inspection: Gray ward, Eliot ward, Kingsley ward, surgical assessment units (SAU) on levels two, three, and four, the theatre assessment unit, the west London vascular and interventional service, the post anaesthetic care unit (PACU), the theatre recovery unit, the main theatre suite, and the discharge lounge. The service had 13 theatres, of which 11 were in use. One theatre was being refurbished and one theatre was being converted into a paediatric recovery.

To manage staffing and capacity during the COVID-19 pandemic, the trust had restructured surgical services and treatment pathways. Northwick Park Hospital provided non-elective surgery and patients underwent pre-assessment care at Central Middlesex Hospital. As part of our inspection of surgical care at Ealing Hospital and Northwick Park Hospital, we visited Central Middlesex Hospital to understand the pre-assessment pathway and the post-treatment therapy provided by allied health professionals. We have included the findings in our surgery report for Ealing Hospital.

We rated surgery at Northwick Park Hospital good overall because:

- The service managed staffing well and maintained consistent levels of training and appraisals despite pressures on the service caused by COVID-19.
- Services were demonstrably multidisciplinary, and staff had established a wide range of new working opportunities to support patient outcomes.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- Pharmacy cover on wards was limited due to short staffing. This meant pharmacists could not always join ward rounds and could not always review prescriptions daily.
- The service did not have a coherent, overarching vision for what it wanted to achieve. Individual departments and divisions developed their own strategies in the absence of a trust-level approach.

Medical care (including older people's care)

Requires Improvement ● ➔➔

Is the service safe?

Requires Improvement ● ➔➔

Mandatory Training

Staff received and kept up to date with their mandatory training. The trust's key performance indicator (KPI) dashboard recorded 87.3% compliance with mandatory training, this was better than the trust's 80% minimum standard.

Mandatory training included: conflict resolution; health and safety; infection prevention and control; information governance; manual handling; and fire safety. We found the overall mandatory training completion rate for nursing staff was 88.6%.

Medical staff were compliant with the trust's mandatory training minimum standard of 80%. The overall mandatory training rate for medical staff was 86.35%.

Basic life support (BLS) training was mandatory for nursing and medical staff. At the time of inspection 83.07% of nursing staff. This was within the trust's 80% minimum standard. However, 72.2% of medical staff had up to date BLS training. This meant there was a risk of some staff not having up to date skills in resuscitation.

Staff received a notification from the trust's learning and development team and their line manager when training was due to be updated.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training met the needs of patients and staff. Staff demonstrated understanding of the types of abuse people may experience. We saw information on how to report safeguarding was available on all wards we visited.

Staff received training specific for their role on how to recognise and report abuse. Following our inspection, we requested current compliance rates in accordance with intercollegiate document guidance. This provides a clear framework which identifies the level of safeguarding competencies required for all healthcare staff.

Medical staff had 86.9% compliance with level 2 safeguarding adults training and 85.4% for level 2 safeguarding children training which was above the trust's 80% minimum standard. Compliance for safeguarding children level 3 was 100%.

Compliance rates for nursing staff in level 2 adult and children safeguarding was above the trust's minimum standard at 93% and 92%. Safeguarding children level 3 compliance was 80%.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff demonstrated understanding of spotting the types of abuse patients may experience. Information on how to report safeguarding was available on all the wards we visited. Patients where safeguarding concerns were identified had risk assessments and care plans in place to manage safeguarding risks.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a specialist safeguarding team. Staff told us if there were safeguarding concerns, they would liaise with the trust's safeguarding team. Staff were able to show us the contact details for both the trust's and local authority safeguarding teams. The trust had a dedicated safeguarding nurse on duty, 24 hours a day, seven days a week.

The trust had safeguarding vulnerable adults and children's policies and guidelines that provided staff with information on actions to take in the event of safeguarding concerns. Safeguarding information was readily available to staff on the trust's safeguarding team's intranet pages.

Staff told us 'prevent', (this is training to support vulnerable people at risk of becoming involved in terrorist activities), and female genital mutilation (FGM) training was included in their mandatory safeguarding training.

We spoke with a middle grade doctor on the acute medical unit (AMU) who was able to tell us who the safeguarding team were and how to contact them. They had safeguarding training at induction but had not had any further training and told us that they felt this would be useful as they often make safeguarding referrals but never learn about the outcomes.

Safeguarding champions were identified on the care of the elderly wards. As part of this role, staff were sent for study days to attend the best practice in dementia training which was accredited by a UK university.

Cleanliness, infection control and hygiene

The service-controlled infection risks well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

We saw that staff washed their hands regularly prior to and after providing episodes of patient care and used hand cleansing gel at regular intervals. Each bed and side room had access to individual hand cleansing gel dispensers, and these were also located at the entrance to the ward to encourage public and staff to use prior to and upon leaving the department. Staff followed infection control principles including the use of personal protective equipment (PPE). Staff had access to PPE including gloves, aprons and masks. We saw staff using appropriate PPE during our inspection.

Curtains separating cubicles were visibly clean and had been replaced on a regular basis.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. We saw that equipment such as commodes and hoists were cleaned after use and marked with 'I am clean' stickers. All equipment we reviewed was visibly clean.

Environmental cleaning and hand-hygiene audits from September 2021 to January 2022, showed compliance rates of over 90% across all wards within the integrated medicines division month-on-month. We were told that it had been encouraging to see that handwashing had increased especially during the COVID-19 pandemic. Actions following the initiation of these audits were to: follow up staff education with hand hygiene competency validation; institute scheduled hand hygiene audits as part of the trust's infection prevention and control program; give feedback and on the spot education if individual hand hygiene performance does not follow guidelines; and encourage accountability, questions and a culture of safety that is not punitive.

Medical care (including older people's care)

The integrated medicines division generally performed well for cleanliness. We viewed a divisional infection prevention and control audit dated October 2021. This recorded that three wards were partially compliant, and improvement was required for the remaining four wards. Action plans were produced in response and monitored at monthly infection control meetings as part of divisional reporting. However, the report did not include the individual names of the wards, which meant CQC were unable to assess performance on individual wards.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

The service had suitable facilities to meet the needs of patients' families. However, we saw a wheelchair on the discharge lounge with torn foot straps. Staff told us the wheelchair was waiting to be collected and removed by medical engineering staff. However, the wheelchair could have been inadvertently used as it was on the ward.

Patients could reach call bells and staff responded quickly when called. A call bell audit in August 2021, demonstrated that the division received a 97.6% scoring for call bells being answered in an appropriate time frame. It received a scoring of 85.4% for call bells working and within easy reach of patients. The division took a 'snapshot' audit in the second week of February 2022 to review call bell access and response rate on a sample of 10 wards. Results showed that there was 93% compliance for call bells in reach, with only five beds out of a total of 93 that were noted to not have call bells in reach. These were in Haldane and Fletcher Wards. Work was in progress to repair faulty call bells.

Staff carried out daily safety checks of specialist equipment. Staff were carrying out routine checks on resuscitation equipment to ensure they were fit for purpose.

The service had enough suitable equipment to help them to safely care for patients. We saw medical engineering staff routinely checked equipment and equipment was clearly labelled with stickers showing dates when checks had been completed and renewal dates.

Staff disposed of clinical waste safely. Waste in clinic rooms was separated in accordance with Health Technical Memorandum (HTM) 07-01, control of substance hazardous to health and the Health and Safety at work regulations.

We saw sharps bins available in treatment areas where sharps may be used. This was in line with health and safety regulation 2013 (The sharps regulations), 5 (1) d. This is a requirement to place secure containers and instructions for safe disposal of medical sharps close to the work area. Labels on sharps bins had been signed, which indicated the date it was constructed. However, we saw a sharps bin in the discharge lounge which was unsteady as stacked on top of another sharps bin. The sharps bin was open and had not been signed or dated. There was a risk of the sharps bin being knocked over and potentially causing harm to patients or staff.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff assessed patients in key areas such as falls, skin integrity, venous thromboembolism (VTE), and nutrition on admission using national risk assessment tools. In the records we looked at, staff had completed appropriate risk assessments including nutrition, pressure ulcers and skin integrity. Staff made use of the national early warning score (NEWS2) to identify deteriorating patients based on variations in different observations such as heart rate, blood pressure and oxygen levels.

The service used a sepsis screening tool, which was used to determine if a patient was suspected to have sepsis and a sepsis algorithm, which outlined a clear process for what healthcare professionals were to do in the event of a patient having sepsis.

The service was regularly reviewing the effectiveness of sepsis management. The trust monitored the management of sepsis through the use of its 'Sepsis Bundles'. In information provided to us, results showed that between January 2021 and January 2022, there had been 674 completed sepsis screening tools, with the highest use in April 2021 when 99 were used. The lowest completed month was for February 2021 when 32 were used. Antibiotics were given timely and appropriately in 609 cases.

Most of the wards under the division of integrated medicine have achieved 100% in the monitoring of NEWS2. Jonson ward was one of the wards that did not achieve 100% compliance, only achieving 50% compliance in for the month December 2021.

We were told that for the areas that were still below the required expectation, the division had started to incorporate NEWS 2in their training via "Stop Listen and Learn", an initiative that was started to address some learning needs in the nursing and healthcare assistant teams. Other areas of development were achieved through courses to support staff in NEWS2 and escalation of triggers. We were also told that NEWS2 escalation remained a focus point of discussion using the ward communication tool.

The service was using a confusion care pathway (CCP), which was an initiative designed to help identify and support patients who had additional needs encompassing their memory, namely delirium or dementia. The confusion care pathway prompted the multidisciplinary team to identify people with memory impairment; assess and treat causes of confusion; communicate effectively with carers/families; consider Mental Capacity Act 2005 (MCA). The CCP was available in the adult inpatient care needs assessment booklet.

The service had an 'Observation and Escalation Policy'. The policy provided a framework for safe clinical care for patients within the acute setting of the trust. The framework included: type and frequency of physiological observations; use of the revised National Early Warning Score (NEWS2); Paediatric Early Warning Score (PEWS); a clinical response strategy; and use of the SBAR communication tool. The policy particularly applied to patients that either presented as unwell or deteriorated and required escalation for their care in order to reduce the risk of morbidity and mortality.

Nurse staffing

The service had enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The integrated medicines division was currently rebranding, marketing, and developing recruitment brochures for the wards. We were told that: adverts had been redrafted and updated; the division was working with their communications team to advertise on social media platforms; they had rolling adverts on NHS Jobs; were implementing new ways of working by introducing new roles; and were involved in the Capital Nurse Rotation Programme.

The integrated medicines division had committed itself to a campaign of overseas recruitment to attract nurses into the division. Out of that campaign, targeted interviews had been held for integrated medicine, five cohorts had been recruited; 50% had commenced employment, with further cohorts in mid-March to be interviewed.

There was a 'One Stop Shop' for HCA recruitment supported by HR, Occupational Health and Ward Managers. The integrated medicines division's plan was to have zero vacancies by May 2022.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Nursing staffing levels were assessed using the National Safer Nursing Care Tool (SNCT). Managers and staff told us when there were nursing shortages on the roster, these would usually be made up from bank or agency staff. Staff worked flexibly across services. However, wards and departments occasionally worked without the established number of nursing and healthcare assistant staff. The trust explained that this would be mitigated with staff being redeployed from better staffed areas on the day.

The highest vacancy rates within nursing were seen amongst Band 2s and Band 5s. The wards with the highest vacancy rates were Fletcher (Care of the Elderly), Fielding (Care of the Elderly) and Elgar (Infectious Diseases). Five Band 2s and fourteen Band 5s were expected to take up roles in the division by the end of March.

The division had started a collaborative project with Dietetics and Surgery to introduce nutritional assistants. The first cohort started 21 February 2022. The established therapy and rehab assistants programme implemented in RHRU (Regional Hyper-acute Rehab Unit) was a programme to be rolled out to Older People Wards across Northwick Park and Ealing in collaboration with other divisions.

We were told that there had been successful recruitment of student nurses across the division and they were supported to join temporary staffing as a band 4 whilst they waited for NMC (Nursing and Midwifery Council) PIN registration.

Managers told us they limited their use of bank and agency staff and requested staff familiar with the service. Managers made sure all bank and agency staff had a full induction and understood the service prior to commencing work on the wards.

We were told that the vacancies and turnaround amongst AHP (Allied Health Professionals) were a challenge, however, the teams met daily to ensure that the patients who needed to be reviewed were done so within the required time frame. The expansion of a single assessment form across all wards has also aided spread of workload there by ensuring patients are seen in a timely manner.

The division had been involved in a cross-divisional project to employ ward based nutritional assistants to cover mealtimes Monday to Sunday on care of the elderly wards. This would be an apprenticeship role, at band 2 for the first 18 months, progressing to band 3. The intention was that the posts would improve patient's nutritional intake, clinical outcomes, patient flow, and support workforce challenges.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Acute medicine consultants were on site from 8am until 9pm, seven days per week covering the acute floor, same day emergency care (SDEC), high dependency unit (HDU) and the medical take. From 9pm to 8am there was a designated on-call consultant via phone who would attend on site, if required. We were told that the division were in the process of increasing consultant night cover from April, but until that time they would put those shifts out to bank.

Medical care (including older people's care)

The service had enough medical staff to keep patients safe. We reviewed data provided by the trust regarding the total number of medical staff broken down by grade for February 2022. We found there were enough medical staff across the specialisms and medical staff matched the planned number, except for: older people's medicine nephrology, where the rate of locum use for consultants was 100%.

The service had reducing vacancy rates for medical staff. Managers told us the service were doing well for junior doctors, but, found the recruitment of specialty registrars and registrars a challenge. At the time of inspection, the service was advertising five registrar roles.

We viewed data on medical staff vacancy rates dated 24 February 2022. There were 19% consultant vacancy in older people's care; 18% consultant vacancy in endocrinology; 32% consultant vacancy in rheumatology; 14% consultant vacancy in respiratory; and 50% specialist registrar vacancies in Stroke and 32% senior house officer (SHO) vacancies in older people's care. Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Medical staff had rotas and specialty rotas. Managers told us cover for inpatient rotas could be difficult and could require agency cover.

We saw on the divisional risk register that there was a risk to patients coming into harm due to delays in them being reviewed due to consultant staffing vacancies in rheumatology. To address this, bank shifts were being filled by a retired consultant and there were ongoing recruitment efforts involving agency for fixed term appointments; and the addition of a personal assistant to assist one consultant at Ealing Hospital so that one consultant could be released to cover at Northwick Park Hospital.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

We found patient records were not always completed in accordance with guidance on the document. For example, we reviewed a nurse admission booklet on Fielding ward. The booklet did not contain the patient's details, nurse names, and only included a staff signature at the bottom of the form. We also saw that some of the boxes for recording patient information had not been completed.

On one patient's notes that we looked at out of the four notes we viewed, we saw that a telephone consultation with family members had taken place.

We saw a 'do not attempt cardiovascular resuscitation' (DNAR) form on Herrick ward where it was unclear whether the patient's DNAR had been cancelled. Staff were unable to tell us the reasons for the cancellation.

There was a system of 'intentional rounding'. This was a structured approach which demonstrated patients had checks at set times to assess and manage their fundamental care needs. We found patients records demonstrated staff regularly repositioned patients in accordance with their care needs; offered drinks; and assisted patients with their toileting needs.

In the patient records that we looked at, it showed that patients had been seen within 12 hours of admission, and patient observations were recorded and completed at correct intervals/NEWS2 scores were calculated correctly and escalated where appropriate.

Records were not always stored securely. We saw records cupboards were not locked when not in use on Darwin ward. Staff told us the cupboard was never locked during the day. This meant unauthorised people may have been able to access patients' confidential information.

The trust's medical wards had suspended records audits during the COVID-19 pandemic. The trust informed CQC that records audits were part of the audit programme for 2022/23.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines. Medicines (including controlled drugs) were stored in automated dispensing cabinets which enabled staff to track medicines use. Staff felt the automated cabinets had reduced the incidence of missed doses. However, also said that they felt it sometimes delayed medicines administration.

The air conditioning unit in the clinical treatment room where most medicines were stored on Gaskell ward was broken. Whilst there was a fan to keep the ambient temperature down, temperature readings above 25 degrees were recorded. However, the trust had a policy for managing temperature deviations to minimise the degradation of medicines and any associated risks. As a result, there was no concern that people were receiving medicines that were not fit for purpose.

Specially trained pharmacists were able to prepare medicines lists on discharge summaries. This was part of a project to save time and reduce the number of transcribing errors.

Medicines advice and supply was available seven days a week. An on-call pharmacy service was available outside of core working hours.

All prescription charts that we looked at included the allergy status of the patient. However, we saw that the VTE indication was not always specified on the patient's prescription chart.

Staff stored and managed medicines and prescribing documents in line with the provider's policy. Medicines were stored in dedicated secure storage areas with access restricted to authorised staff.

Staff followed current national practice to check patients had the correct medicines. Pharmacists checked what medicines the patient was taking (medicines reconciliation). They also recorded the reason why a medicine was stopped, started or a dose was changed.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. Staff were able to give examples of incidents, including where action had been taken to prevent reoccurrence. Learning was shared in a variety of ways, for example 'stop, listen and learn' sessions were held daily on the ward.

A medicines management audit undertaken in January 2022 showed compliance of 98.4% across the integrated medicine division. Most wards scored 100% compliance but Jonson Ward and RHRU scored 94% and 92% respectively. Medicines management audits were not applicable across three of the wards within the division.

Medical care (including older people's care)

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

All staff knew what incidents to report and how to report them. Staff told us that learning from incidents was regularly shared with staff via emails. However, a doctor on Darwin ward told us they were not aware of a medicines incident which had occurred on the ward.

Staff raised concerns and reported incidents and near misses in line with trust policy. All staff could describe incident reporting processes in line with trust policy.

Training in the Deprivation of Liberty Safeguards (DoLS) and Mental Capacity Act 2005 was mandatory.

From 01 February 2021 to 31 January 2022 the service had 2727, broken down into the following categories of harm: Near miss (102); no harm (1351); low harm (1164); moderate harm (101); severe/major harm (5); and death (4). Under the type of incidents, clinical incidents (incidents that could or did affect a patient) was the type category that had the most recorded incidents. This amounted to 2307. Medication errors and accidents that may result in personal injury were the subcategories contributing to this high number of incidents.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. We reviewed three root cause analysis (RCA) serious incident investigation reports. We found these to be thorough. Relevant staff were involved in investigations. RCA reports included a chronology of events. RCA reports demonstrated patients and their families were involved in investigations and informed of actions taken as a result.

Managers debriefed and supported staff after any serious incident. Serious incident investigation reports identified support provided to staff. For example, all the RCA serious incident reports we reviewed identified specific support offered to staff including the support of senior managers and the trust's occupational health team.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. We saw from a review of three root cause analysis (RCA) serious incident investigation reports that patients and family's views were sought, and outcomes of serious incident investigations were shared with them. details of duty of candour discussions with patients and families were documented.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Medical care (including older people's care)

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Guidance and best practice guidelines from the trust and the National Institute for Health and Care Excellence (NICE) were accessible to staff on the trust's intranet. Staff told us guidance was easy to access.

We viewed a selection of the trust's policies and procedures and saw these referenced legislation and guidance that underpinned the policy. For example, we viewed the trust's standard operating procedure (SOP) for the 'Management and Identification of Medical Outliers in Non-Medical Wards'. The SOP clearly identified actions staff should take in the event of outlying patients and recorded contact details for all medical and wards used for outlying patients. (Outliers were patients recorded as being under a medical specialty but receiving care and treatment on a surgical ward).

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patients with mental health needs were discussed at the daily safety huddle. Care plans and risk assessments, together with any actions needed to mitigate risks were identified at the huddles.

Endoscopy had recent joint advisory group (JAG) accreditation rated as outstanding. However, the accreditation was deferred due to a new unit and processes being embedded.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

At the time of inspection due to the trust's COVID-19 visiting policy, patients requiring support with eating and drinking were allowed one visitor a day, as long as the visitor was supporting the patient with feeding.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The trust offered a finger food menu and offered menus for patients unable to place their own menu order, staff could tick the options for the patients.

Patients had access to a range of menus that met their religious and cultural needs. For example, a kosher menu, vegan menu, allergy aware menu, and modified texture menu for people with difficulty swallowing. The trust could also provide translated menus in other languages, braille and large print.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All the nutritional assessments and fluid balance charts we viewed were complete and up to date. Where a dietitian had been involved in a patient's care, this was documented. We viewed the outcome of a malnutrition universal screening tool (MUST) audit for the month of January 2022. This recorded 96.8% of MUST records were completed correctly, this was within the trust's audit standard of between 90% and 100%.

We reviewed the outcome of a monthly fluid balance management audit dated January 2022, this found compliance with completion of fluid balance charts was 88.75% for the integrated medicines division. This was due to two wards not meeting the trust's 96% to 100% standard. These were Gaskell, which scored 82%; and Herrick, which scored 80%.

Staff said patients were offered seven hot drinks a day and regular water rounds. Patients were offered three snacks a day, as well as breakfast, lunch and dinner. The trust used a 'red tray' system to identify patients requiring support with eating.

The medicines division had submitted a business case to the trust board for three new roles of nutritional assistants; this was to support staff on the wards with patients requiring support with eating and drinking.

We were told that there was a focus on nutrition and hydration, as it was paramount to elderly care, hence the role of nutrition champion on each ward, which was strengthened and supported in partnership with dietetics, matrons and ward managers. Nutrition champions wore a badge to distinguish their role.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

The pain team was a clinician led service. A named consultant anaesthetist was the trust lead for pain management. The acute pain nursing team consisted of 2.93 WTE Band 7 and 3.35 WTE Band 6 and they had a presence on all three hospital sites.

The service also had a head of nursing who oversaw this service. There is a fixed rotation on each site for continuity of care, but staff were flexible to cover other sites if needed. Rotas for February and March for the pain team showed that there were at least two nurses from the team who were able to cover Northwick Park Monday to Friday.

The daily remit of the acute pain nursing team was to have a safety briefing at 9am. Ward rounds would be undertaken to see new patients with patient-controlled analgesia (PCA), epidural or rectus sheath infusion, and follow up other patients seen the day before. Referrals coming into the team were reviewed, every first and third Tuesday of the month. Teaching in pain management was also provided to ward nurses on a 1:1 or 1:2 basis as requested.

We viewed results from the integrated medicines division's monthly quality audit programme April to September 2021. This found the lowest rate of patients who felt their pain had been managed appropriately was 96% in April and July 2021, the highest rates were 100% in May, June, August and September 2021.

Patients we spoke with told us they received pain relief soon after requesting it.

The service was unable to provide information about how the service implemented the 'Faculty of Pain Medicines Core Standards' for pain management.

Patient outcomes

Staff monitored the effectiveness of care and treatment. The service had been accredited under relevant clinical accreditation schemes. However, the hospital was not meeting national standards in some areas of the myocardial ischaemia audit.

The service participated in relevant national clinical audits. The COVID-19 pandemic delayed the piloting and rolling out of some national audit data collection.

Outcomes for patients were positive, consistent and met expectations, such as national standards. The trust had introduced a new electronic application to monitor patient outcomes. At the time of inspection, the trust informed CQC that their quality dashboards were being updated to reflect the new audit programme which consisted of six-monthly nursing audits. Results from the audits were produced on an application (app) to enable staff in accessing audit results from a variety of media.

Medical care (including older people's care)

We viewed results from the nursing profile audits on the app. This recorded that all wards across the integrated medicines division were meeting the 90% minimum standard for: cannulas (peripheral and central); falls; hand hygiene; national early warning score (NEWS2); nutrition and hydration; Waterlow audits or pressure ulcers.

We were told that the trust and the division had no formalised audit mechanism relating to mental health. The trust did not meet the criteria to be included in the National Patient Survey for Mental Health.

The 'Myocardial Ischaemia (MINAP)' heart attack audit for 2021 found patients having echocardiogram after STEMI was 92% at Northwick Park Hospital, this was higher than the 76% national average. (ST-Elevation Myocardial Infarction (STEMI) is a very serious type of heart attack during which one of the heart's major arteries is blocked).

The MINAP audit found patients with suspected STEMI door-to-balloon (D2B) time, (this is the interval between patient arrival at the hospital to balloon angioplasty of the occluded coronary artery), within 60 minutes was lower than the 74% national average at 7%. The trust was not a designated London heart attack centre and therefore saw very few STEMI patients appropriate for primary percutaneous coronary intervention (PCI). Percentages were lower than the national average because the trust saw fewer than 20 patients in the reporting period.

The MINAP audit found the number of patients at Northwick Park Hospital who were referred to cardiac rehabilitation was lower than the national standard of 81% at 4%.

The audit action plan stated that there was no cardiac rehabilitation programmes available in Brent and Harrow and that the trust had established links with a local NHS community healthcare trust to set up local programmes. It specifically stated that consultant cardiologist support was provided during scheduled multidisciplinary team meetings (MDT) meetings, and the nurse consultant was actively working with the community healthcare trust's colleagues. Following the inspection, the trust told us they had been successful in obtaining central funding to set up cardiac rehabilitation services for Brent and Harrow with funding to be released in May 2022.

Managers used information from the audits to improve care and treatment. Results of the 'Heart Failure National Audit 2019-2020' found a mixed picture from the key areas of the 2018-2019 audit. In response to the audit the trust had an improvement action plan in place to address areas identified as requiring improvement. The action plan had a clear process of monitoring and review.

There were 35 medical care outliers on surgical wards as of 9 February 2022. In a process for Management of identification and management of medical outliers in non-medical wards document, it stated that medical outliers were inpatients under the care of Specialist Medicine or Gastroenterology, who were cared for in beds that were not one of the 'home' ward beds. At admission, patients had a recommendation for which team should provide their care on the post-take ward round. This was entered on the electronic patient record system and was available to the bed management team when the patient was allocated a bed. When there were insufficient medical beds available, the patient was placed in a surgical ward as an outlier. At the time of inspection, on 9 February 2022, of the 627 general and acute beds open, 622 were occupied. On 10 February 2022, of the 628 general and acute beds open, 608 were occupied.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

All integrated medicines wards had agency and bank staff local induction folders. Any new agency/bank staff working on the ward complete a check list on arrival to that ward.

Medical care (including older people's care)

A spot audit completed for the months of January and February 2022 to show whether agency and bank staff had received a local induction showed results that an induction folder was in place across all wards within the integrated medicines division. Comments arising out of the audits stated that "the need for induction was discussed with staff on shift", and "rare use of agency staff – ward manager ensures staff are inducted".

Bank and agency staff working on ward departments were provided with an orientation checklist to familiarise them to the wards and departments, as well as being provided with policies. Items on the orientation checklist included: an introduction to ward/department staff and multidisciplinary team/key personnel; being shown the layout of wards including restrooms and store rooms; being shown the location of clinical notes and referral forms; being shown the location of fire doors; being shown the location of a cardiac arrest trolley; and being shown the nurse call bell system and emergency call bells. Policies shown included medicines management, infection control, health and safety, information governance and raising concerns (whistleblowing).

Managers supported staff to develop through yearly, constructive appraisals of their work. We viewed the integrated medicines division's key performance indicator (KPI) dashboard dated January 2022. This recorded that 90.33% of staff had received an annual appraisal, this was better than the trust's 80% KPI standard.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing and healthcare assistants, we spoke with told us they received regular supervision.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The service had a configuration of job plans to appeal to medical staff working in older people's services but could also offer medical staff experiences in different disciplines. The service was also looking at some medical staff working a 'half and half' job role across two specialisms.

The clinical educators supported the learning and development needs of staff. The practice development nurses (PDN) provided daily 'Stop Look Listen and Learn' sessions. This was a video conference teaching platform for nurses and health care assistants (HCA). The sessions facilitated staff to access training flexibly and develop skills and knowledge in a structured and consistent approach, as well as opportunities to share best practice. The sessions provided PDN with the opportunity to continuously evaluate staff learning needs so that relevant and appropriate teaching materials could be created to focus on different topics every week.

The PDN had completed focused ward-based group training. This included all clinical staff receiving training in the National Early Warning Score (NEWS2) and sepsis. Emergency care training was covered in acute life-threatening events recognition and treatment (ALERT) training. There was also a bedside emergency assessment course tailored for healthcare staff (BEACH) training, this training was in addition to mandatory training to enhance their skills in identifying deteriorating patients. The integrated medicines division had also completed daily NEWS2 teaching using revised teaching materials created by the trust's critical care outreach team. All staff had access to a certificated NEWS2 e-learning course, including healthcare assistants (HCA).

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us they were emailed minutes of team meetings.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example, Macmillan nurses trained the trust's cancer clinical nurse specialists (CNS).

Medical care (including older people's care)

Managers identified poor staff performance promptly and supported staff to improve. We viewed three serious incident root cause analysis (RCA) investigation reports. These identified learning points for staff as a result of incidents.

A development day for the internationally educated nurses was designed specifically, which covered nutrition, speech and language therapy (SLT), dementia, tissue viability nurse (TVN), diabetes; and medicine management, which was hosted by the PDN and speakers from different specialities.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings (MDT) to discuss patients and improve their care.

Staff worked across health care disciplines and with other agencies when required to care for patients. The integrated medicines division worked closely with the division of emergency and ambulatory care to provide acute assessment and same day emergency care.

When patients received care from a range of different professionals, this was coordinated. Multidisciplinary teams were involved in assessing, planning and delivering patients care and treatment. Staff collaborated to understand the range and complexity of patients' needs. For example, cancer services had worked with Macmillan and received an occupational therapist OT as a result of this.

The hospital had a range of allied health professionals that supported medical and nursing staff. Staff told us nurses and doctors worked well together within the medicine's division. There were daily multidisciplinary board rounds which included, nurses, doctors, OT and physiotherapists.

All medical wards had an allocated physiotherapist and an occupational therapist on weekdays. Physiotherapy and occupational therapy weekend cover was provided by a on call rota whereby the clinician would be on site to support patients.

Dietetics was a mainly adult inpatient service with a workforce that included dietitians and dietetic assistants.

The trust had a podiatry team that worked flexibly across the trust, but primarily Northwick Park and Ealing Hospitals.

Individual speech and language therapists (SLT) were not allocated to specific wards/ medical teams. SLT covered all areas. Work allocation was dependent on referrals for SLT services.

Staff referred patients for mental health assessments when they showed signs of mental ill health, or depression.

Patients had their care pathway reviewed by relevant consultants. We viewed the trust's 'organogram', this was an organizational chart that detailed the speciality pathways for patients attending the hospital. A consultant reviewed care and treatment based on the patient's care speciality.

The trust was a joint tertiary centre for head and neck cancer, with another London NHS trust. The oncologists sat with the other NHS trust, but were part London North West University Healthcare Trust's multidisciplinary team. Staff told us working with other trusts on cancer pathways was effective.

Medical care (including older people's care)

A senior manager in cancer care told us accountability needed to be clarified in cancer multidisciplinary working. The manager said ward teams needed to be clear on whether they were requesting an opinion from the cancer team or whether a patient was being referred to the cancer team.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on their care pathway, seven days a week.

The inpatient wards at Northwick Park Hospital were always open and medical staff were always available to provide patient care and advice. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Occupational therapy (OT) and physiotherapy cover included weekend cover. The workforce resource across these two disciplines was stretched from five to seven days to provide cover. At the weekend the teams would prioritise service needs as it was not a full seven-day service. The use of therapists over the weekend meant that they could facilitate discharges or commence assessments of new patients, thereby enabling a better flow of patients in the week. We had been told that the model of stretching resource to provide cover during the weekend had been successful in reducing the Monday funnel of patients awaiting discharge, as well as enabling weekend discharges.

The dietetics service was offered Monday to Friday. Staff resource and skill set did not allow for a seven-day service.

SLT offered a Monday to Friday service except in stroke where there was a six-day service but was dependent on skill mix, which also took into account a limitation of Band 5 staff available to undertake swallow assessments.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Information on the COVID-19 vaccine was available on the trust's website.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff gave patients information on smoking cessation, exercise and diet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Mental Capacity Act (MCA) and Deprivation of Liberty Safeguards (DoLS) training was incorporated in Safeguarding Adults Level 1 and 2 training modules. Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards. Staff told us the MCA and DoLS training was mandatory for all staff. Deprivation of liberty only occurred when it was in a person's best interests and was a proportionate response to the risk and seriousness of harm to the person, giving due consideration to the least restrictive option that could be used to ensure the person got the necessary care and treatment. Senior nursing staff and doctors we spoke with could describe the processes they would follow to initiate 'deprivation of liberty safeguards' (DoLS).

Medical care (including older people's care)

Staff were trained in dementia awareness. The dementia training standards framework was commissioned by Department of Health (DOH) together with Health Education England (HEE) and aims to support the development and delivery of dementia education for the healthcare workforce. LNWH dementia awareness training had recently been redesigned to become compliant with the guidelines so that all staff were confident in the provision of person-centred care to patients with dementia/delirium needs.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff had understanding of capacity and consent issues and were able to describe the correct process for establishing capacity and obtaining consent. Staff knew where they would get further advice if needed. Staff told us there had been a drive at the trust on developing staff understanding of the MCA.

Staff clearly recorded consent in the patients' records. Staff gained consent from patients for their care and treatment in line with legislation and guidance. We found in the records we viewed that consent to care and treatment was obtained in accordance with legislation and guidance, including the MCA. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded.

Staff made sure patients consented to treatment based on all the information available. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Patients aged 16 and over who lacked the capacity to make a decision, a decision was made by applying the 'Best Interest' principle, as set out in the MCA.

Staff could describe and knew how to access policy and get accurate advice on MCA and DoLS. The trust's safeguarding team had a road map for the implementation of the Mental Capacity (Amendment) Act (MCA) 2019 and the introduction of the Liberty Protection Safeguards (LPS) which will replace the Deprivation of Liberty Safeguards (DoLS). As a result of the amendments to the Mental Capacity Act NHS trusts will be expected to authorise and oversee deprivation of liberties instead of local authorities. The safeguarding team had published information on LPS in the staff PULSE newsletter and were attending ward managers and matrons' meetings to inform staff of the changes.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff were aware of the need to protect the privacy and dignity of patients and relatives. For example, drawing curtains during examinations and covering people when examining them during ward rounds.

Patients said staff treated them well and with kindness.

Medical care (including older people's care)

Staff followed policy to keep patient care and treatment confidential. Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff told us they offered relatives private space to talk when needed.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Patients and families had access to a multi-faith chaplaincy.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. For example, the service had a guide for staff in talking to patients and families when a patient was deteriorating. The guide offered recommended phrases to use with patients and their families like: “we’re doing our best to look after you”, instead of phrases like, “there is nothing more we can do for you”. Another example of a recommended phrase was: “at the moment we are doing our best to prevent any suffering”, rather than, “these drugs will let him / her die without suffering”.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Cancer services had a policy that the telephone was always answered to provide emotional support and advice to patients and families. If the phone was answered by a band 4 cancer support worker who would take a message and pass it on to the patient’s clinical nurse specialist. Staff told us cancer services placed importance on patients having access to immediate support when contacting the service.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The trust had recently appointed a new head of patient experience. Chaplaincy and bereavement services were part of the patient experience team. The team monitored patient experience, including the outcomes of the Friends and Family Test (FFT) and national patient surveys. The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. The trust had recently recruited a head of patient experience. The head of patient experience told us their role was to understand what mattered to patients and families.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. The service used the friends and family test (FFT), This was benchmarked at 94%. The service had been achieving the benchmark since 2021.

Medical care (including older people's care)

Staff supported patients to make informed decisions about their care. For example, cancer services had introduced a patient led follow up in breast, colorectal and urology. Staff told us cancer services were trying to move away from an over medicalised model of care and treatment.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the changing needs of the local population.

The number of admissions for the three specialties most admitted to in the division of integrated medicine at Northwick Park Hospital in January 2022 were: general medicine with 1040 admissions; infectious diseases with 23 admissions, geriatric medicine with 17 admissions.

Gastroenterology was not part of the integrated medicines division, as it was a specialty in the St Marks division. In the period 1 November to 31 January 2022 there had been 581 admissions in gastroenterology.

Cancer services were trust wide. Staff told us cancer services were “very integrated” in north west London. The trust had cancer clinical nurse specialists (CNS) for all the main tumour sites. Staff worked in their specialist teams. These teams sat within a larger cancer team that worked across the entire cancer pathway.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust informed us there had been no mixed sex breaches in the 12 months prior to the inspection.

The division of integrated medicine did not include the acute medical unit (AMU) or the CDU/HDU, as this sat in the division of emergency and ambulatory care division. The AMU provided 48 acute beds. The integrated division of medicine also did not include haematology. The haematology department provided 23 beds and sat under the ICS division.

Gastroenterology, Frederick Salmon South, sat with St Mark’s Hospital. St Mark’s is managed by London North West University Healthcare NHS Trust and is the only hospital in the world to specialise entirely in intestinal and colorectal medicine and is a national and international referral centre for intestinal and colorectal disorders. Frederick Salmon South ward provided 24 beds.

Staff could access emergency mental health support 24 hours a day seven-days a week for patients with mental health problems, learning disabilities and dementia. However, staff told us managing patients with mental health needs was becoming increasingly challenging, due to an increase in the number of patients presenting with mental health needs. Staff told us they were increasingly expected to manage patients in mental health crisis. Staff said this was further

complicated by a lack of availability of registered mental health nurses (RMN) to provide one to one care for patients with mental health needs. Staff said due to a shortage of mental health beds at suitable mental health facilities patients experiencing acute mental health crisis were often on the wards for prolonged periods, even when they were fit for discharge to mental health services.

The trust had suspended its trust-wide patient led assessments of the care environment (PLACE) assessments as a result of the COVID-19 pandemic.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff told us the hospital faced a challenge in planning services to meet the needs of patients with mental health needs. Staff said patients with mental health needs were often medically fit for discharge, but had to wait for three days or more due to the lack of availability of mental health beds. This meant the Northwick Park Hospital bed was unavailable to patients requiring a bed, until a mental health bed was available to the patient.

The trust had a dementia matron and a band 7 clinical nurse specialist to support the wards with care planning for patient with complex mental health, dementia and learning disabilities. The trust had dementia champions, these were staff members (clinical or non-clinical) who had a keen interest in dementia care and could ensure seamless delivery and development of dementia care.

Wards were designed to meet the needs of patients living with dementia. The confusion icon was a symbol which provided a way of identifying patients who required extra support. The symbol was placed as an electronic tag on the patients record system and hung magnetically above the patient's bed to ensure that those living with dementia, delirium and/or memory impairment could be easily identifiable by staff so that their care was planned appropriately.

Staff supported patients living with dementia and learning disabilities. On admission patients who presented with memory loss or confusion were put on the confusion care pathway. This was an initiative designed to help identify and support patients who had additional needs encompassing their memory.

The service offered pictorial menus and menus with larger print, as well as coloured crockery, modified cutlery and coloured trays to discreetly identify people in need of additional support with eating and drinking.

The trust had a learning disability and autism pathway for patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust's 'hospital passports' scheme for patients living with a learning disability and autism, allowed patients to identify to staff their preferences and dislikes in a pictorial format. There was also an 'easy read' menu available for patients. The trust had two learning disability nurse specialists to support patients with their care and treatment.

The service had information leaflets available in languages spoken by the patients and local community. The trust had access to software that could provide translation of written materials including British Sign Language (BSL) upon request. For example, leaflets and trust letters.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us interpreters were available both in person and via the telephone. We saw a form staff could use to request face to face interpreters, for patients where English was not their first language. The form had instructions for staff on booking interpreters prior to appointments to ensure they were available to support patients during an appointment. Staff could also book telephone interpreters. However, we found some ward clerks were not clear about the procedure for accessing interpreters via the phone.

Staff had access to communication aids to help patients become partners in their care and treatment. Patients that used sign language, could book an interpreter with the trust in advance of their appointment. Northwick Park hospital was equipped with a hearing loop, this is a special type of sound system for use by people with hearing aids, this greatly reduced background noise, competing sounds, reverberation and other acoustic distortions that reduced the clarity of sound.

Access and flow

The trust was not meeting the referral to treatment national standard but had a recovery plan in place and was working jointly with the ICS to focus on achieving pre-COVID-19 activity levels.

Patients were admitted under a lead speciality. If that team required another team's input due to it being identified that the patient had a condition which should be managed by another team, this would be facilitated by a ward based transfer to the correct admissions unit, and not via the emergency department (ED). We viewed the trust's 'organogram', this was an organizational chart that detailed the speciality pathways for patients attending the hospital.

There were weekly integrated medicines divisional inpatient performance and flow meetings. These meetings monitored and were accountable for flow and the operational performance of in-patient wards within the integrated medicines division. The meeting was attended by general managers, matrons from both Northwick Park and Ealing Hospitals, the divisional information analyst and a patient flow facilitator. The group reviewed KPI by site, reported on local improvement initiatives and any shared learning within the division.

In January 2022 the trust was in the highest 25% of all trust's nationally at 100% for the proportion of cancer patients treated within 31 days of a decision to treat. However, the trust was not meeting the national 85% target for patients treated within 62 days of an urgent GP referral at 78.24%.

We reviewed trust wide data for referral to treatment times (RTT). In March 2022 there were 56200 patients on the waiting list, this was an increase from February 2022 when there 55500 patients on the waiting list. There were 465 patients that had waited over 52 weeks in March 2022, but this was a reduction on the previous month when the figure was 562 patients. The overall trend in consultant led referral to treatment times from January 2021 to January 2022 was downwards. This meant the trust were addressing the backlog of patient waiting for care and treatment as a result of the COVID-19 pandemic.

We saw trust wide data for January 2022, this indicated that 100% of patients in elderly medicine and general intestinal medicine consultant led referral to treatment waited less than 18 weeks:

94.8% of cardiology patients received care and treatment within 18 weeks of referral: 95.9% of patients in respiratory medicines were seen within 18 weeks of referral; 95.9 % of patients in respiratory medicine were seen with 18 weeks: 84.7% of patients were seen within 18 weeks in "other medicine", and 14.6% of "other medicine" patients were seen within 18 to 26 weeks.

Staff told us they tried not to move patients at night but if this did occur, they were discussed at morning safety huddles.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. The trust defined in-hours discharges as discharges between 7am and 8pm. Out of hours discharges were defined as discharges between 8pm and 7am. Out of hours discharges were recorded on the electronic patient record system.

Between January and December 2021 there had been 17,866 patients discharged between 7am and 8pm. There had been: 938 patients discharged between 8pm and 10pm; 292 patients discharged between 10pm and midnight; 291 patients discharged between midnight and 7am. There was a total of 1521 out of hours discharges, or 8.5% of discharges taking place out of hours. The trust informed us that there could be an element of error with out of hours discharges, due to the system not being updated until the ward clerk was on shift. Ward clerks worked from 9am to 5pm and did not work at weekends.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The integrated medicines division had weekly qualitative and quantitative reviews of unplanned and planned discharges and compared this with patients estimated dates of discharge on the electronic patients record system. Following the weekend, general managers undertook a review with the weekend duty doctor and charge nurse of each ward. Reasons for unsuccessful planned discharges were discussed and documented. Plans for new discharges were also discussed and documented. This information was reviewed weekly at the divisional flow meeting.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. All the patients we spoke with said that they had not raised any complaints with the hospital, as they had not had any. Patients said they thought staff were approachable if they did wish to raise issues.

Information regarding complaints was available on all the wards. Staff told us information in other languages could be requested from the trust's accessible communications team.

The service clearly displayed information about how to raise a concern in patient areas. Information on the patient liaison service (PALS) was displayed on noticeboards in the hospital and available on the trust's website.

Staff understood the policy on complaints and knew how to handle them. Complaints were managed in accordance with the trust's policy and lessons were learnt. Staff and managers told us they preferred to resolve minor complaints at ward level. Staff told us these were not recorded, but if they could not deal with the complaint immediately, then patients and families would be directed to the patient advice and liaison service (PALS) to make a formal complaint.

Managers investigated complaints and identified themes. Complaints were monitored on the integrated medicines key performance indicator (KPI) dashboard. For example, the monthly traffic light, (red, amber, green) dashboard for January 2022 had a red rating due to the division having received three complaints in the month.

Medical care (including older people's care)

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The patient experience team worked with the complaints team in reviewing patient complaints. Staff told us the main themes from complaints were clinical care; communication and information; and staff attitude.

Managers shared feedback from complaints with staff and learning was used to improve the service. There were weekly divisional patient experience and complaints response tracking meetings. The meetings tracked and monitored divisional complaint responses. Divisional managers, heads of nursing, matrons, the divisional governance team, and a patient relations manager attended the meeting to ensure quality, accuracy and compliance against the trust response target. Once a month an extended meeting was held to focus on any themes from complaint to update the action log relating to complaints. Learning from the meetings was shared with medical specialty leads.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

At the time of our inspection, a new chief executive officer had taken up their role in the trust.

The integrated medicines division was headed by a triumvirate, comprised of a divisional clinical director, a divisional director of operations and a divisional director of nursing. The divisional clinical director had a deputy.

There were five general managers responsible for thirteen services which included the regional hyper-rehabilitation unit, stroke, neurology, department of medicine for older people (DMOP), cardiology, dermatology, respiratory, infectious diseases, rheumatology, nephrology, diabetes and endocrinology and integrated sexual and reproductive health, who reported to the divisional director of operations.

There were two site-based heads of nursing (one dedicated to the Northwick Park Hospital site) who reported to the divisional director of nursing. There were also specialty-based matrons who reported into the Northwick Park Hospital head of nursing.

The division was supported by a clinical governance team of two.

Each of the specialities had a clinical lead and a general manager. All specialities with exception to dermatology had a matron.

Staff felt that leadership visibility had improved and increased since the introduction of video conferencing, because there could be 500 people attending a video conference call and there would be greater questioning and answering on any issue, whether it was a clinical matter or non-clinical matter.

Medical care (including older people's care)

Leaders would still try and maintain a balance of personal contact but because of the COVID-10 pandemic numbers still being prevalent, face-to-face meetings were limited and there were fewer social events, although some glimpses of normality had led to some increases in meetings.

We were told that he adoption of virtual clinics had been proving successful. There was however still a need to accommodate those patients whom were either without computer access or those patients who were not IT comfortable.

The divisional governance lead and the general manager for integrated medicine were keen to tell us that the chief nurse of the trust and her team were highly visible on the wards.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The service's vision was to provide safe, effective and responsive patient care that was reflected in practice, both for emergency medical admissions and for complex specialist outpatients. To deliver this vision, the service ensured that they embedded a culture of compassionate care with proactive engagement, communication, and involvement of patients, families and their carers; ensured that every patient was cared for in the right inpatient environment; every patient had the investigations and treatment they needed quickly, and to the service's highest standard; and supported their staffs' wellbeing, ensuring they had professionally rewarding working lives.

The trust recognised that for the service's vision to be a success, a number of objectives would have to be met, which included: delivering timely care and achieving their access targets; delivering and progressing timely treatment to safe discharge, and making the best use of their precious inpatient bed resource; and recruiting and retaining quality staff.

We reviewed the trust's clinical strategy 2018-2023 which mentioned cancer services as part of the trust's overall clinical strategy. However, the trust did not have a local cancer strategy in place; however, they were working to national targets on cancer waiting times and locally delivering on the NHS long term plan which included their work with another provider. Examples included: early diagnostic/rapid diagnostic centre (RDC); faster diagnostic standards; and personalised care packages, such as stratified follow ups for breast cancer and the development for prostate and lower GI patients, which had been delayed due to the COVID-19 pandemic.

The general manager for integrated medicine and the divisional governance lead for medicine told us that the vision and strategy was communicated at divisional meetings and via monthly newsletters and regular governance meetings focusing on values. They said that the divisional strategy was in line with the trust's strategy. When we asked what it meant to them, they said that it involved retaining good quality staff and making the trust an attractive place to work and encouraging high calibre staff to apply to work at the trust.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Medical care (including older people's care)

We were told that the legacy of uncertainty at Ealing Hospital had previously affected relationships across both sites but that had now settled, and people could concentrate on contribution to the trust. The creation of cross site functions had alleviated that uncertainty and strengthened greater contributions from staff at all levels.

There was more recognition that all roles and promotions did not come from Northwick Park Hospital. We were told that there were still pockets of a 'us and them' attitude towards Ealing Hospital but it had lessened. COVID-19 had changed and encouraged much more team working across the trust and across sites.

Seniors from the integrated medicines division said that the service was quite representative of the multi-cultural population they served, with service teams and matrons now being employed from mixed backgrounds. There was a huge focus on setting up monthly meetings for black and minority ethnic (BAME), with staff from the BAME network being interviewed for opportunities within the division.

We were told that good rates of nurse recruitment were being taken up from oversees candidates equating to 60% of nurses within the trust.

There were good procedures put in place for bullying and harassment, such as the Freedom to Speak Up Guardians, with posters advertising this. Staff knew where to go to access their Freedom to Speak Up Guardians**.**

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Mortality and morbidity (M&M) were reviewed as a specialty cross site. The division reviewed the morbidity and mortality reports monthly at the divisional governance meeting presented by the head of Clinical Effectiveness. Minutes from their most recent meeting in January showed that mortality data was compared against what was being reported nationally, mortality was being compared against other divisions within the trust, there was monitoring of completed mortality; and there was learning from themes in mortality across the trust.

The specialties took it in turns to present at the divisional quality and risk meeting. Their presentations included mortality and morbidity reviews and learning. The specialties also had regular mortality and morbidity meetings, with mortality and morbidity updates and learning also being a standing agenda item at specialty clinical governance meetings.

The division of integrated medicine clinical governance structure stated that each specialty had responsibility for overseeing and maintaining appropriate governance over their clinical activity, in line with national and trust standards of care, safety, quality and patient experience. We saw minutes from cardiology, endocrinology and respiratory where cases were discussed in detail, where good aspects of care were identified but also episodes of care which needed to be improved upon.

Handover meetings took place at 07:45 and there were ward based meetings at 08:15. Divisional meetings took place at 08:45 followed by an overall site meeting, which took place on video conferencing. We were told that other ways in which the trust promoted safety and governance were to have 2pm ward level "touch point" handovers that looked at risks and needs.

Safety huddles also took place, and these were forums to discuss issues from the previous day and current day, to enable planning for the current working day and to raise any urgent issues. Meetings were attended by representatives of both medical and nursing staff.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

When asked about understanding of priorities and issues the service faces the response was that the priority was to deliver safe and effective care. They stated that divisional and trust priorities were communicated via structured meetings such as daily safety huddles and multi-level video conferencing meetings at ward, divisional and site level (The COVID-19 pandemic has caused greater reliance on online video conferencing meetings and this has proved an improvement and beneficial in terms of communication to staff groups) There were also periodical newsletters emphasising individual priorities. When questioned repeatedly on this area there was no volunteering of an overall list of priorities or strategy that they were aware of. There was more focus on specific areas such as, for example, complaints and NICE guidance. The multi-layered daily video conferencing meetings gave managers and some staff the opportunity to see what was happening across the entire trust and allow for speedy mitigation of any problems arising on a day to day basis.

The trust used traffic light (red, amber, green) rated key performance indicator (KPI) dashboards to monitor quality and performance. Monthly reports were produced and monitored by senior managers. The dashboards covered essential areas of quality and safety, such as: NHS safety thermometer, this is a measurement tool for improvement in health care, which focuses on the most common harms to patients; patient experience; and workforce and safer staffing.

The medicines division had regular board meeting with structured agendas. The meetings discussed 72-hour reports, these are reviews of serious incidents.

All wards had quality boards which were linked to the CQC key lines of enquiry (KLOE) of safe, effective, caring, responsive and well led. The boards had information for patients, visitors and staff on the wards performance with regards to the trust's key performance indicators (KPI). This demonstrated openness from the trust with regards to the performance of wards and departments.

The trust had moved from a paper-based system of quality assurance audits to an electronic application to monitor quality and performance at ward level. A new app had been introduced in October 2021. A quarterly report was produced from the information ward staff inputted into the app. The first report from the app covered the period October 2021 to December 2021. The second report was in progress at the time of the inspection.

We were provided with meeting minutes for four divisional quality and risk meetings. Minutes from meeting that took place on 24 November 2021, showed that items discussed at this meeting included: performance issue, which looked at length of stay, diagnostics and waiting times; open national patient safety alerts; a review of the risk register; NICE guidance; and a governance review.

There were 23 risks on the divisional risk register for integrated medicine. Risks on the risk register were RAG rated, had review dates and dates for which risks were to be completed and come off the risk register. The highest rated risk for integrated medicine at Northwick Park was the risk of patients being compromised and needing to move them bed because of lack of oxygen and suction ports at all bed positions on Fielding Ward. The trust mitigated this by having a

provision for portable oxygen cylinders and portable suction units. The actions required against this risk noted on the risk register were: to incorporate installation of oxygen and suction outlets at each bed position where it was ideal; have extra portable suction units and oxygen cylinders; and have a policy on moving patients at certain NEWS2 scores, with pre-emptive moves to bed positions which have oxygen and suction.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had a patient data management system.

Managers told us cancer services had built a digital system to track patients across north west London. The system would align the trust's cancer services with other providers in the integrated care system (ICS). The system had been rolled out in breast cancer care, but services were in the middle of the digital change. The digital alignment meant patient care and treatment could be tracked wherever they received it. The system was due to be rolled out in other cancer services in April 2022.

Staff told us the trust had invested in a new digital patient record system, but staff were unsure of the timelines for the roll out. The system would align patient records with other trust's across north west London. However, some staff told us the trust had too many IT systems and thought they could be streamlined. Staff told us the trust's current IT systems required staff doing double entries across different IT systems and this consumed staff time.

Staff told us there was a trust wide risk relating to the way junior doctors worked and accountability for the patient tests. Staff told us there was a lack of systems in place for lead clinicians to ensure patient tests were reviewed promptly. Staff said this was as a result of junior doctors not working every day. We reviewed the junior doctors' rota which showed that all medical care wards had a minimum of one junior doctor based on each ward from 9am to 9pm on weekends and bank holidays, in addition to full to teams Monday to Friday. Staff also told us IT systems did not have checks and balances and concerns could be missed as they were not always picked up in a timely way.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The service had virtual staff forums. The trust had introduced a 'civility' programme to encourage appropriate behaviour towards colleagues.

Staff told us the service was encouraging a 'no blame' culture regarding the reporting of incidents.

'Freedom to speak up' is an initiative encouraging a positive culture where people feel they can speak up and their voices will be heard. The division had designated 'Freedom to speak up' champions, which included both nursing and medical staff.

The management team had conducted staff listening events. Managers told us they had found these events useful in terms of hearing staff feedback and concerns.

Medical care (including older people's care)

The trust had a workforce race equality standards (WRES) improvement action plan 2021/2022. This included fairer recruitment processes including black and minority ethnic (BAME) employees sitting on recruitment panels and managers justifying non-selection of BAME for impact.

The trust workforce race equality standards (WRES) improvement action plan 2021/2022 reported that trust wide 99% of staff had completed equality and diversity training.

The trust workforce race equality standards (WRES) improvement action plan 2021/2022 reported 24% of white staff and 22% of BAME staff reported experiencing bullying and harassment from colleagues.

17% of all staff of all ethnicities reported experiencing bullying and harassment from managers. In response the trust had implemented an action plan to address concerns, including implementation of a comprehensive bullying and harassment plan linked to the trust's HEART behavioural framework. The timelines for this plan to be completed was April 2022. The plan included: reviewing the trust's bullying and harassment toolkit and continuing to embed the HEART bullying and harassment tool; encouraging staff to challenge poor behaviours from colleagues.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Staff told us that their training and development needs were met. Training needs analysis for staff was done regularly with a focus on more ward based training, for example care of the elderly – focus on kindness and compassion and coping with difficult patients; falls training and serious incidents training; and more intense safeguarding training for junior staff.

We were told that there was a focus on promoting leadership training for levelling up opportunities, although dedicated leadership courses were halted because of COVID-19.

There had been opportunities for staff to work in transformation team, with there being a lot of secondment opportunities. Protected time was given to staff for a 'stop listen and learn' initiative.

Surgery

Good ➔➔

Is the service safe?

Good ➔➔

Our rating of safe stayed the same. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. At the time of our inspection 92% of staff were up to date with mandatory training.

Mandatory training was detailed and met the needs of patients and staff. Practice development nurses and other specialist trainers delivered in person training to supplement online e-learning.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Clinical managers supported staff to access training updates.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so.
Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Overall compliance for medical and nursing staff for safeguarding 1, 2 and 3 was 98.6%. Staff involved with pre-assessment and discharge planning undertook extended training to recognise and mitigate risks.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. They knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Staff had good knowledge of the trust safeguarding lead's role and how to contact them. They were clear on escalation pathways and what to do if they had urgent concerns about a patient out of hours.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children admitted to adult wards. In each instance staff alert the hospital paediatric lead nurse and submitted an incident report form. They used a specific information record for patients aged 16 to 18 to help them coordinate safe care. The information record prompted staff to carry out safety checks such as if the child was known to social services or the child and adolescent mental health services (CAMHS) team.

Surgery

Cleanliness, infection control and hygiene

The service controlled infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff placed brightly coloured 'I am clean' stickers on equipment when it had been sanitised and were ready for use.

The service performed well for cleanliness. The infection prevention and control (IPC) team carried out monthly audits of wards and theatres, including hand hygiene and environmental cleanliness checks. Clinical managers maintained a continual oversight of this data through ward audits.

Staff used records to identify how well the service prevented infections. They followed infection control principles including the use of personal protective equipment (PPE). Staff adhered to the trust's 'bare below the elbows' policy during all of our observations.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment sterilisation took place off site with another provider under a service level agreement. Staff said the system worked well although very small printing of labels on surgical packs meant they spent additional time checking contents.

Staff worked effectively to prevent, identify and treat surgical site infections.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and we saw the staff responded quickly when called.

The design of the environment followed national guidance. The design of the environment followed national guidance. The service was compliant with the Department of Health and Social Care (DHSC) Health Building Note (HBN) 00/09 in relation to clinical environment design.

Each theatre had a separate anaesthetic room and a clean preparation room, with access to the 'dirty' corridor used for staff with contaminated clothing and for managing dirty equipment. Pre-theatre changing and scrub areas appropriately segregated changed and unchanged staff.

The recovery ward had 15 identical bays with full monitoring equipment and piped gasses.

Staff carried out daily safety checks of specialist equipment. All theatres were equipped with identical anaesthetic machines and mobile monitors. This reflected good practice and contributed to good safety standards. Staff consistently and spontaneously told us their positive feelings about clinical equipment. Across surgical specialties staff said they were happy with modern, well-maintained equipment at their disposal.

Each ward and clinical area had a resuscitation trolley. This included a defibrillator, airway equipment of different sizes, and emergency medicines. Staff documented daily and weekly safety and security checks.

All 10 of the items of electrical equipment we checked had up to date service and electrical safety documentation.

Surgery

The service had suitable facilities to meet the needs of patients' families. The trust had suspended usual visiting rules for families to reduce the risk of COVID-19 infection. Where a patient would benefit from the presence of a family member or carer, they provided access to the hospital's family accommodation.

The service had enough suitable equipment to help them to safely care for patients. Theatres were modern, well equipped and included full radiological facilities. Air filtration systems met national standards. Safety stickers on theatre equipment indicated servicing checks were due in November 2020.

Theatre staff had improved equipment management protocols as a result of auditing team debrief records. The new process meant a theatre support worker prepared instruments and equipment the day before planned surgery. This helped to identify any stock or availability problems in advance.

The service used a digital record for each theatre, which enabled staff to track patients moving through the various stages of treatment. This meant the team could effectively track capacity, availability, and decontamination protocols.

Staff disposed of clinical waste safely. Staff disposed of clinical waste safely in line with DHSC Health Technical Memorandum (HTM) 07/01 (2013) in relation to the safe management and disposal of healthcare waste.

The service was compliant with DHSC HTM 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste.

Staff maintained good health and safety standards around all areas of surgical services. Corridors were free from clutter and evacuation escape routes were fully accessible.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff used the National Early Warning Scores second generation (NEWS2) clinical risk management system to monitor patients for signs of deterioration. We found observation charts were clearly written and up to date and there was evidence of appropriate escalation when patients needed additional clinical input.

We saw that staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly. Theatre briefing protocols were in line with World Health Organisation (WHO) guidance and staff followed a clear, methodical brief using prompts from the patient care plan. Staff followed time in, and time out recording procedures and signed these accurately.

Staff followed the WHO five steps to surgical safety checklist for each procedure in theatres. The trust audited standards of checklist performance monthly and staff demonstrated consistently good levels of practice. Between April 2021 and January 2022, the theatres team achieved 100% compliance with the requirements of the checklist.

Staff knew about and dealt with any specific risk issues. Staff routinely and consistently completed risk assessments for venous thromboembolism (VTE), pressure areas using the waterlow tool, and for sepsis. Staff documented specialist referrals and outcomes of risk assessments.

Surgery

We found the staff worked to make improvements in risk assessments and procedures as a result of learning. For example, theatres staff implemented more detailed checks of skin integrity when patients arrived from the ward. The team identified this as an area for improvement after a review of findings in theatre debriefs.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others. This included completion of 'ceiling of care' assessments, which helped staff to identify when to contact palliative care or end of life care teams.

Shift changes and handovers included all necessary key information to keep patients safe. We observed consistent practice between handovers, such as between an operating department practitioner (ODP), anaesthetist, and nurse. The team included a clear summary of the patient's procedure, their care plan, and observations to be continued. During a planning meeting, consultant anaesthetists led an effective handover between shifts with junior anaesthetists and the theatre coordinator.

Nurse staffing

The service had enough nursing, allied health professional, and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

We found there were enough nursing, allied health professional and support staff to keep patients safe.

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Nurse to patient ratios on the recovery ward was maintained at one to one and other clinical areas consistently maintained safer staffing level requirements.

Senior staff could adjust staffing levels daily according to the needs of patients. Three nurses staffed the recovery ward overnight, which enabled the surgical team to run emergency lists.

The service had variable vacancy rates. For example, the recovery ward was fully staffed whilst the head and neck service relied on agency nurses to maintain care. Gray ward had vacancies for four full time registered nurses and staff said it was increasingly challenging to fill shifts. However, vacancy rates were generally improving. Overall, in surgery, nurse vacancies in April 2021 were 17%. This had improved significantly to 7% by February 2022.

The service had low and/or reducing turnover rates. A practice development nurse (PDN) worked across the surgical division in this hospital and undertook staffing support projects. For example, they worked with the team on Evelyn Ward to improve staff retention during the pandemic.

The service had increasing rates of bank and agency nurses. Senior staff described a good response when they needed approval for agency nurse cover from the head of nursing or divisional director. Agency staff received a full induction.

While student nurses gave consistently positive feedback about their experiences in the hospital, they rarely applied for posts after their placement. Staff told us feedback around this reflected the very high levels of need presented by the increasing number of patients with dementia.

Surgery

Managers made sure all bank and agency staff had a full induction and understood the service.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. Consultant surgeon and anaesthetist rotas were fully covered despite one unfilled vacancy.

Vacancies were low and the service was recruiting for one consultant anaesthetist and one musculoskeletal consultant.

Managers reported difficulty accessing locums when they needed additional medical staff, particularly to cover the emergency rota.

Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. The trust welcomed clinical fellows on specialist pathways from other hospitals and services. One vascular fellow told us they felt teaching was “excellent” and said they appreciated extensive operative training and good standards of supervision.

The service always had a consultant on call during evenings and weekends. Consultants spoke positively about the structure of the on-call rota and said it promoted patient safety.

Records

Staff kept detailed records of patients’ care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were detailed and all staff could access them easily. Staff documented care and treatment notes clearly and included their grade, name, and time. This reflected best practice.

When patients transferred to a new team, there were no delays in staff accessing their records. All members of multidisciplinary care teams documented their reviews and interventions in patient records.

Records were stored securely with locked access for paper records and encryption for digital records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. In theatres we observed good labelling practices for anaesthetic agents and syringes.

Theatre staff carried out audits of anaesthetic medicines in line with national standards. The audit checked safe documentation, preparation, and administration.

Staff reviewed each patient's medicines regularly and provided advice to patients and carers about their medicines. Specialist pharmacists in anti-coagulation and antimicrobial prescribing support clinical teams. This improved capacity in the service as it meant pharmacists could test patients for allergies and support nurses to administer medicines using enteral feeding tubes.

Staff completed medicines records accurately and kept them up to date. In a sample of 10 patient records we looked at staff had fully completed each with details of prescribed medicines and allergies. Staff prescribed antibiotics and VTE prophylaxis in line with national guidance. In all cases staff had written legibly with a date, signature, and grade of clinician.

Staff stored and managed all medicines and prescribing documents safely. Pharmacy cover on wards was limited due to short staffing. This meant pharmacists could not always join ward rounds and could not always review prescriptions daily.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services. Pharmacists checked medicines continuity to ensure patient safety, such as ensuring patients maintained their usual routine for essential medicines prior to surgery.

Staff learned from safety alerts and incidents to improve practice. The trust required staff to undertake three observed assessments carried out by three different assessors as part of their competency training. This ensured objectivity and assessor vigilance. The practice development nurse (PDN) and ward managers used a learning approach in the event of a drug error incident. The encouraged staff to reflect on the incident and then identify additional learning and support needs. This may include observation of practice as part of an individualised approach.

Each ward had a locked medicines room with secure, digital access that followed good practice. Staff separated fluids that contained potassium as part of a comprehensive safe storage plan. A named nurse each shift led Controlled Drug (CD) safety and storage and the pharmacy team audited CD management quarterly.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. In the previous 12 months, staff reported 3809 incidents, of which 3563 were clinical incidents. Clinical ward managers used weekly quality checks to ensure staff received feedback and outcomes from recent complaints. Staff told us they felt the hospital had a learning culture and they were confident to report incidents without fear of blame.

Staff raised concerns and reported incidents and near misses in line with trust/provider policy. Managers shared learning about never events with their staff and across the trust.

Managers reviewed incidents to identify themes and opportunities for learning and changes in practice. At the time of our inspection the most common incident theme was length of stay in the recovery ward.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong.

Surgery

Staff received feedback from managers in relation to investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care. The PDN used incident reports as learning and development opportunities as part of a strategy to reduce risk. For example, they noted increased incidence of pressure damage in patients with 'cricket pad' splints and used improved training to reduce this trend.

Managers investigated incidents thoroughly and used a quality and governance tool to track response times.

Is the service effective?

Good 

Our rating of effective stayed the same. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Staff prioritised surgical treatment for patients who presented to the emergency department (ED). For example, patients who suffered a transient ischaemic attack (TIA) underwent surgery within 48 hours, which is national best practice for stroke prevention.

Staff adhered to trust standard operating procedures when planning patient care. For example, the recovery ward did not accommodate ventilated patients overnight.

At meetings and safety rounds, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. This included during multidisciplinary planning meetings, post-operative reviews, and discharge planning meetings. Staff used escalation pathways to coordinate care and referrals with specialists.

The practice development nurse acknowledged the lack of a national orthopaedic nursing framework accreditation scheme for staff. They worked with other organisations to identify suitable alternatives to maintain an evidence base for practice.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs. The theatre coordinator planned lists with consultant anaesthetists to enable patients to drink water if their operation was not imminent. Patients waiting to have surgery were not left nil by mouth for long periods. The theatre coordinator worked with ward staff regarding the timings of patient surgery to enable patients to drink during delays.

Staff fully and accurately completed patients' fluid and nutrition charts where needed and documented changes to nutritional status in care plans.

Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition and maintained up to date nutritional risk assessments.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

We saw that staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used an intentional rounding process to monitor patients for pain and discomfort.

Patients told us they received pain relief soon after requesting it. Patients across multiple wards and departments told us they were happy with how staff were managing their pain. They felt confident to raise concerns about levels of pain and said staff reacted quickly when they requested pain relief.

Staff prescribed, administered and recorded pain relief accurately. They maintained continual observations after a surgical procedure and documented changes in patient's clinical needs and how they described pain levels.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national and local clinical audits. Divisional and clinical leadership teams monitored a programme of rolling audits, including those designed to benchmark standards and results against standards set by the National Institute of Health and Care Excellence (NICE). Submission rates of audits were monitored monthly using the trust wide national clinical audit exception report. For the year 2020-2021 Northwick Park Hospital participated in 99% (70/71) national clinical audits.

Ward managers used a programme of monthly rolling audits to build action plans for improvement with support from matrons.

The speech and language therapy team participated in national benchmarking of patient outcomes in the video fluoroscopy service. This measured radiation doses from X-Rays and the timing of procedures. The team contributed to national studies and monitored the causes of higher radiation doses, such as for patients with complex metalwork in their body.

Outcomes for patients were positive, consistent and met expectations, such as national standards.

Interventional radiology was available 24-hours, seven days a week and the team worked with surgeons as part of regional trauma transfer arrangements to ensure patients had access to complex diagnostic care. The team worked between hospitals and other trusts and provided a coordinated service.

Surgery

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Staff delivered care and treatment competently and in line with best practice and their training. For example, we saw surgeons use safe moving and handling practices in theatres when safely positing patients.

The trust gave all new staff a full induction tailored to their role before they started work. A new theatre support worker said they felt supported, enjoyed their induction, and felt it was useful for their role. They noted feeling "empowered" within the team and said they felt able to speak up to ask questions during surgical procedures.

Managers supported staff to develop through yearly, constructive appraisals of their work. At the time of our inspection 91% of staff were up to date with appraisals.

Staff spoke positively about this process and noted managers supported them to access advanced training through the process, such as a Masters programme. A nurse in the interventional radiology team completed advanced training that enabled them to carry out line insertions, which the senior team were rolling out more broadly as part of a plan to build capacity. The same team enrolled nurses into sedation training to enable them to provide more complex care.

Practice development nurses (PDNs) supported the learning and development needs of staff. The team maintained information displays on each ward to help staff keep up to date with training information and support them to access developmental opportunities.

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff said safety meetings and e-mails from managers were helpful and they felt involved in the running of the hospital as a result.

A PDN supported staff with clinical education in the wards, theatre assessment unit and surgical assessments units.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff in each clinical area maintained education boards to support colleagues in building specialist skills and knowledge. For example, the team on Eliot Ward maintained a sepsis awareness board to support staff in their knowledge and practice.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Staff spoke positively about opportunities for career development and said the senior team worked to support them with this.

Managers made sure staff received any specialist training for their role. The PDN worked with ward managers to support staff to achieve competencies, such as an 'IV passport' and training for point of care testing.

Managers identified poor staff performance promptly and supported staff to improve. The PDN supported staff with lower levels of motivation to undertake advanced training and helped staff identify good opportunities to use their three-yearly financial allowance for external training.

Surgery

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care. Each clinical service established multidisciplinary processes that reflected patient needs. This was a flexible process and meant staff could arrange meetings and reviews at key points in treatment pathways. For example, the trauma team operated on a multidisciplinary model including medical doctors, anaesthetists, surgeons, and trauma physiotherapists. The whole team planned and coordinated care from an early stage.

Staff worked across health care disciplines and with other agencies when required to care for patients. Staff reported positive experiences of interdepartmental collaboration and there was a culture of proactive multidisciplinary meetings whenever it was in the best interest of the patient. This included meetings between staff at different trusts for aneurysm cases and meetings to review the management of vascular patients. The theatre coordinator liaised with the anaesthetist on call at national confidential enquiry into perioperative deaths (CEPOD) planning meetings. CEPOD relates to emergency theatre lists during normal working hours.

The portering team had introduced a new workflow management system using a smartphone app. This improved efficiency and meant porters could work more flexibly in the hospital and responding quickly to patient moves.

The speech and language therapy team arranged multidisciplinary meetings with community services for patients who lived out of the local area. This helped to improve continuity of care after discharge and reflected a proactive approach to long-term care.

Staff referred patients for mental health assessments when they showed signs of mental ill health. There was limited provision for urgent inpatient mental health review and this process often took place in the community after a patient was discharged.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. The surgical team had a well-established seven-day service and patient notes reflected regular doctor reviews.

Staff could call for support from doctors and other disciplines such as allied health professionals, mental health services, and diagnostic tests, 24 hours a day, seven days a week. Clinical and support services operated trust-wide based on the specific surgical care provided. Where a service was not available directly on site, staff at another site provided cover. This included from hospitals in other trusts based on service level agreements.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards. Staff signposted patients to specialist organisations to help them following discharge, such as for managing heart conditions or living more healthily with cancer.

Surgery

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. The allied health professional (AHP) team took a lead role in this provision and worked at the preassessment stage and post-surgical care planning stage to incorporate health promotion into rehabilitation pathways. Staff tailored this to individual needs, such as for patients who wished to return to sports and those who would benefit from a healthier diet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Consent was obtained from patients for their care and treatment in line with legislation and guidance. We saw consistent standards of consent obtained and documented at each stage of treatment, including from the preassessment stage.

When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Designated on-call senior staff supported this process.

Staff made sure patients consented to treatment based on all the information available. Patients told us they felt involved in the treatment decision-making process and understood the implications of consent.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. As young people sometimes received care on adult wards, staff ensured they had up to date knowledge.

Clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. They knew who to contact for support when providing care for patients with complex needs.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Surgery

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed examples of this throughout the inspection, including during a patient transfer from ward to theatre and patients in the discharge lounge. Staff maintained privacy and dignity and were gentle and compassionate in their interactions with patients.

Patients said staff treated them well and with kindness. Patients told us staff were caring and attentive. One patient said they were “impressed” by the speed of an urgent operation from scan to admission and another patient described the theatre admissions unit (TAU) team as “wonderful.”

Staff followed policy to keep patient care and treatment confidential. We observed discreet conversations between staff that protected patient’s identity Staff were mindful of data confidentiality and kept printed records and computer screens locked away when not in use.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. We observed examples of this when staff delivered care to a patient who had difficulty understanding their clinical condition.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Staff we spoke with demonstrated compassion and understanding for patients, particularly in relation to those who were anxious because relatives could not visit them. Staff were empowered to address this issue. For example, the team on Evelyn Ward had introduced social events such as tea parties for Halloween and Christmas as part of a programme to improve patient’s emotional wellbeing after surgery.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. For example, staff made time to talk to patients about their worries and provide information on treatment to reduce anxiety.

Patients who became distressed were supported by staff where they were in an open environment and helped them maintain their privacy and dignity. Staff made the most of hospital space and provided patients with quiet areas for personal discussion or privacy.

Training had been undertaken by staff for breaking bad news and demonstrated empathy when having difficult conversations. Staff incorporated health implications and long-term challenges during conversations with patients about treatment plans and consent.

Staff understood the emotional and social impact that a person’s care, treatment or condition had on their wellbeing and on those close to them. Staff were aware of the impact the trust’s COVID-19 ‘no-visitors’ policy had on patients and helped patients to access communication tools to help them keep in touch.

Discharge coordinators worked with multidisciplinary teams to understand and meet patient’s emotional needs at home to enhance recovery outcomes. For example, staff said they often could not find a next of kin for patients before discharge. In such cases they worked with the patient to identify other avenues of support in the community.

Surgery

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Staff in theatres introduced themselves by name to each patient as good practice and staff on wards build a rapport with each patient. Staff who worked between wards, such as therapists, worked closely with patients to establish and deliver rehabilitation plans.

We heard staff talking with patients, families and carers in a way they could understand, using communication aids where necessary. The hospital displayed colour-coded posters that helped patients and visitors understand the different grades and roles of staff. This reflected good practice due to the wide range of staff who worked in the hospital.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. Each clinical area had a patient feedback display and staff included interactive, eye-catching elements to encourage engagement.

Staff supported patients to make advanced decisions about their care. A dedicated palliative care team worked with patients across the trust to establish advanced care plans where their condition was not curable.

Patients were helped by staff to make informed decisions about their care and respected decisions relating to do not attempt resuscitation (DNAR) authorisations.

Patients gave positive feedback about the service. Staff encouraged patients to participate in the NHS Friends and Family Test (FFT). In the previous 12 months surgery services performed consistently well, with 99% satisfaction rate.

Patients in the surgical assessment unit (SAU) told us they felt well informed in decision-making and they appreciated discussions about alternative treatments.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services so they met the needs of the local population. Theatre lists were organised to meet demand. Dedicated theatres were available for maxillofacial surgery, gastroscopy, laparoscopic general surgery, general surgery and national confidential enquiry into perioperative deaths (CEPOD) surgery, and a hybrid vascular and interventional radiology theatre.

Surgery

Consultants told us they were proud of the hospital's development in clinical specialties, such as the regional vascular unit. Most surgeons were also trained in interventional radiology, which meant the service offered 24-hour cover for vascular emergencies.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. Bed managers and coordinators worked with wards teams to reduce this risk.

The team were in the process of converting one adult theatre into a dedicated child recovery theatre in response to increasing presentation from paediatric patients.

Facilities and premises were appropriate for the services being delivered. A dedicated theatre coordinator led the 11 theatres in active use. The interventional radiology team recognised a risk caused by a ventilation problem in the angiogram suite and reflected this in the risk register.

A quiet room and day room for religious use were available.

Staff could access emergency mental health support 24 hours a day seven-days a week for patients with mental health problems, learning disabilities and dementia. Dedicated leads were in post across the trust and staff had easy access to contact and referral options. Out of hours staff used resources such as community crisis services and link nurses to provide support.

The service had systems to help care for patients in need of additional support or specialist intervention. The hospital was a tertiary centre for head and neck, ENT, and voice. The speech and language therapy (SaLT) team provided an extended practice service that included working with consultants to review patients prior to admission, carry out an outpatient follow-up and prepare therapy plans with community partners. The team led a post-operative video scoping clinic for patients following a stroke that supplemented X-Rays by enabling the team to support more specific swallowing therapy.

Staff monitored and took action to minimise missed appointments. They contacted patients who missed follow-up recovery and rehabilitation appointments and arranged extra support.

The interventional radiology team implemented a system that enabled radiologists to offer a non-surgical service for the removal of breast lumps. This reduced patient waiting times and improved capacity in surgery. The senior team planned to expand this approach to further improve treatment options alongside access and flow.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

The service could not always ensure patients living with mental health problems that required specialist input received appropriate levels of care. The trust used an agency to secure registered mental health nurses (RMNs) for patients who needed one to one care whilst in the hospital. However, the agency was not always able to supply enough RMNs and matrons used a safe care tool to redeploy staff.

Surgery

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports. They facilitated visits by carers to help support patients during their treatment, which promoted recovery and comfort by reducing anxiety. Clinical nurse specialists supported ward teams with care planning, capacity, and carer support.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. Staff used resources such as pictorial communication charts and audio-visual software to support complex communication needs.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. This included in person and telephone interpretation.

Patients were given a choice of food and drink to meet their cultural and religious preferences. Catering assistants and chefs took account of individual needs when planning menus and worked with dieticians to ensure food and drink balanced nutritional standards with individual preferences.

Staff had access to communication aids to help patients become partners in their care and treatment. They used hospital resources and digital online resources to help patients take a more active role in understanding care and treatment.

Access and flow

The trust was not meeting the referral to treatment national standard but had a recovery plan in place and was working jointly with the ICS to focus on achieving pre-COVID-19 activity levels.

A dedicated theatre coordinator was responsible for the efficient use of theatre capacity, including regarding CEPOD and the operation of one trauma list. The coordinator worked flexibly and arranged urgent or emergency cases into routine slots where available. The service benchmarked their average length of stay against other trusts nationally. The average length of stay for general surgery in the last six months was five days which was higher than the national average of 2.3 days. This was due to the complexity of provision of colorectal surgery which was part of another speciality and division within the trust. Between September 2021 and March 2022 the theatre cancellation rate for surgery was 12% (372 patients of 3140 procedures booked).

Staff used an electronic theatre planning tool that enabled real time monitoring of theatre utilisation.

The surgical team relocated intensive care and utilised the vacated space into a theatre admissions unit and day case ward to increase capacity. Staff reported the system worked well, with an average of 19 patients treated daily

Some services, such as the post anaesthetic care unit (PACU), was bookable in advance for patients who needed a higher level of short-term post-operative care. This included for thyroid, carotid, and maxillofacial surgery. The PACU team facilitated same-day bed availability on demand when unexpected problems arose during surgery. This reduced the pressure on critical care by providing a facility for short term enhanced monitoring.

The trust was not meeting the referral to treatment (RTT) national standard of 92%, In February 2022 this was 69.2% with 397 patients waiting 52 weeks. The trust ranked 10th out of 18 London acute trusts. The trust had a recovery programme working jointly with the ICS to focus on recovering to pre-COVID-19 activity levels.

Surgery

The trust reported cancer waiting times as a single organisation rather than by site. Between June 2021 and December 2022, for all two week waits, the trust achieved an average of 86% which did not meet the two week wait standard of 93%. As at January 2022, the trust ranked fifth out of 18 acute trusts and had met the standard 14 times out of the last 23 months.

The trust told us that this was due to a combination of factors including outpatient capacity for new and follow up patients caused by COVID-19 restrictions and staff sickness due to COVID-19. The trust has received funding to support additional waiting list initiatives which has helped to improve the backlog.

The trust met three of the six diagnosis standards in January 2022: 31 days decision to first treatment was reported at 100% (the target was 96%); 31 days decision to subsequent treatment (surgery) was reported at 100% (the target was 94%); 31 days decision to subsequent treatment (drugs) was reported at 100% (the target was 98%). The two week wait for suspected cancer was reported at 88.4% (the target was 93%); 2 week wait for breast symptoms was reported at 89.2% (the target was 93%); 28 day faster diagnosis was reported at 68.1% (the target was 75%). In response to this data, the trust had ensured that the straight to test pathways were strengthened and additional capacity arranged where possible in addition to ongoing staff recruitment. The trust also worked jointly with the sector to create further improvements to the cancer pathway to progress to the delivery of the national standards the Trust was meeting prior to the pandemic. The trust had agreed recovery trajectories for 2022/2023.

Managers and staff worked to make sure patients did not stay longer than they needed to. Some patients experienced extended stays on the recovery ward due to wider bed shortages in the hospital. The ward manager submitted an incident report each time a patient reached the threshold of maximum advisable stay.

The surgical assessment unit (SAU) acted as a day unit for urgent/non-elective surgery with capacity for 18 patients per day. Most patients arrived at 7.30am, but there were some staggered admissions. This meant some patients waited long periods of time in the unit before their procedure.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards. This formed part of effective bed planning and service capacity discussions we observed between multidisciplinary staff. Staff used this approach to allocate theatres based on urgency and schedule lists in line with capacity.

It was common practice for medical patients to be accommodated on surgical wards. For example, staff on Gray Ward and on Eliot Ward noted over 50% of their patients were sometimes under the care of medical specialties. Staff said they felt supported to provide safe and responsive care and medical consultants were readily available.

Managers worked to minimise the number of surgical patients on non-surgical wards. A dedicated surgical escalation lead was responsible for flow across eight wards and the surgical assessment unit. The worked with discharge practitioners and integrated medicine leads to reduce delays and bottlenecks whilst managing patients safely. The lead attended daily bed meetings and met with matrons daily to incorporate their feedback and insight into decision-making.

Managers monitored that patient moves between services were kept to a minimum. The trust operated post-operative therapy using a hub and spoke model. This hospital was the hub for therapies such as speech and language and other sites were spokes at which staff delivered pre-planned care. Staff worked across the trust and said the system worked well to maximise access to care without the need to move services.

Surgery

The service moved patients only when there was a clear medical reason or in their best interest. Staff did not move patients between wards at night. Each ward had an escalation bed reserved for patients awaiting a review for complex needs.

Managers and staff started planning each patient's discharge as early as possible. A multidisciplinary discharge hub linked ward teams with community services to improve discharge processes.

The complex discharge coordinator team worked with the surgical escalation lead and ward staff to coordinate discharges. This team joined length of stay meetings to review patients who spent more than 14 days in the hospital. They worked with community teams, who provided in-reach services to the hospital, to expedite discharges safely. Matrons were trialling a new weekend discharge process to improve flow during a period during which staff typically find discharges challenging to achieve.

The AHP team had developed a specialist care pathway for patients not able to weight-bear. This enabled the team to discharge patients to community therapy teams with pre-planned care pathways, reducing their length of stay.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them. Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs. Shortages in pharmacy cover resulted in delayed discharges, particularly for patients with complex medicine regimes. For example, Gray Ward had one hour of pharmacist cover each day, which was insufficient to fully review each patient.

Staff supported patients when they were referred or transferred between services. This included plans to ensure continuity of care and adherence to care plans to achieve positive outcomes.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers told us they knew how to complain or raise concerns. The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them. Managers investigated complaints and identified themes. Matrons had increased weekly cover for investigating and managing complaints in response to increased demand, which improved response times.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. Matrons offered patients the opportunity to join resolution meetings to help conclude investigations and learning.

Managers shared feedback from complaints with staff and learning was used to improve the service. The trust monitored complaints for trends across surgery services. In the previous 12 months, surgery had received 180 complaints.

Staff could give examples of how they used patient feedback to improve daily practice.

Surgery

Is the service well-led?

Good  

Our rating of well-led stayed the same. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

A divisional leadership triumvirate was responsible for surgical services, which reflected the clinical, nursing, and operational aspects of the service. The team had a clear understanding of the challenges faced by the service as COVID-19 hospitalisations decreased and the hospital reassessed the significant changes made during the pandemic. The team was working on a key national priority of reducing waiting list through a combination of running extra lists in the hospital and securing external lists in the independent sector.

A surgical matron, ward managers, and clinical managers led surgical services with variations between their remits. One ward manager led the recovery ward and post anaesthetic care unit (PACU).

Matrons were responsible for patient experience and quality and safety through ward oversight.

Most staff we spoke with described positive relationships with the senior team and said managers were approachable and visible. Staff across departments spoke of consistent standards of safety embedded in good management structures. While overall feedback was good, staff on the surgical assessment unit (SAU) described more challenging experiences. Some staff said they were frustrated with frequent reallocation and redeployment and felt that changes in line management structure had resulted in low satisfaction and poor relations with the senior team.

Vision and Strategy

The service did not have a coherent, overarching vision for what it wanted to achieve. Individual departments and divisions developed their own strategies in the absence of a trust-level approach. Staff were positive about local values and strategy.

Most staff we spoke with were unaware of the trust's strategy and said individual divisions or departments had established their own in the absence of an overarching programme. AHPs said they were focused on empowering staff to improve the patient experience and reduce length of stay through more intensive therapy.

A senior manager described a divisional vision and strategy that was site specific and complemented the trust's corporate vision. The divisional leadership team recognised that while they worked between three different hospitals, each had its own unique properties. They worked with staff to ensure each hospital had its own identity, which would help to drive development following the pandemic. For example, the team recognised Northwick Park Hospital as the main site for complex cases.

Surgery

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The senior team had worked to implement a working culture that was less top-down in hierarchy and that empowered staff at all levels to contribute to the service. Staff told us they felt happy and respected. Staff in various roles spoke of good standards of teamwork and a supportive working culture.

The working culture in theatres reflected World Health Organisation (WHO) international best practice. It was calm and quiet, and staff were focused with clearly embedded protocols.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

A range of staff from surgery participated in monthly trust-wide governance mornings.

Each ward had a governance information board that included incident data with brief summaries of outcomes, link nurse details, safeguarding information and COVID-19 updates.

The interventional radiology team managed risks, incidents, and complaints to their service and worked with the vascular team to coordinate responses and actions.

Senior divisional and department staff encouraged their teams to attend divisional governance meetings to present their audits and outcomes work. This included service evaluations, patient satisfaction work, and validated outcomes.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Staff on each ward used a noticeboard to display key risk and performance information. This included the local risk register, the latest data on mixed sex accommodation breaches and current arrangements for paediatric recovery. Each ward adapted the display to reflect issues and challenges relevant to them. For example, staff on the recovery ward used the stay to track overnight stays, which had peaked in January 2022 and were gradually reducing.

Matrons led a peer-reviewed ‘excellence assessment’ each quarter to assess ward performance and ensure ward teams incorporated complaints, incidents, and patient feedback into their work.

The senior team noted critical care capacity for complex colorectal surgery as a key challenge.

The senior team worked with radiology and radiation protection colleagues to manage X-Ray risks. Staff used appropriate protective equipment and followed national requirements.

Surgery

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Trust policies and standard operating procedures were available digitally. Staff knew how to access these, and the trust used a tracking system to ensure the most up to date versions were always available.

Clinical managers produced easily accessible audit and governance reports using the 'perfect ward' system, which staff used to monitor local data and drive improvements.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust used a number of channels and communication strategies to engage staff. This helped to keep staff up to date on new processes or working arrangements in the hospital, such as a new portering system. One communication platform was computer screensavers, which staff throughout the trust could use to communicate wellbeing opportunities to colleagues. These included access to counselling, support for ill health, wellbeing conversations, and yoga classes. This reflected a broader staff support strategy the trust used during challenging times in the pandemic.

Staff we spoke with said they felt engagement from the executive team was positive and consistent. The executive team visited wards weekly to meet staff and patients as part of a programme of visibility.

The transformation lead worked across the trust to incorporate staff feedback into service and practice improvements.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

Surgeons were working with the Vascular Society for Great Britain and Ireland to expand aneurysm surgery centre provision across London. At the time of our inspection, trust vascular surgeons were only permitted to carry out elective and emergency aneurysm surgery at another trust's hospital to meet GIRFT (Getting it Right Time) requirements. Surgeons told us this meant that there were different operating procedures and practices from their own trust and this caused additional complexity to their work and they felt the ability to perform surgery on site would improve efficiency.

Surgery staff across the trust were inquisitive and explored ways to improve patient experience and outcomes. They integrated this approach to a wide range of development strategies. For example, the team on Evelyn Ward joined a programme to explore reduced levels of mortality as part of their work to reduce loneliness and improve social opportunities amongst patients.

We saw a high standard of service adaptation and safeguarding integrity from the surgery team when treating a patient with a language interpretation need. The patient spoke a language the trust's translation service could not provide and

the surgical team used a combination of a doctor from another department who spoke the language and an online translation tool to ensure they proceeded from the ward to theatres safely. This fully included a consent process and checks to ensure the patient understood their options and what was happening. The theatre team maintained consistent practice compliant with WHO standards and ensured the patient remained fully involved.

The team on Evelyn Ward had secured funding for a new one-year nutrition assistant initiative to support patients with a fractured neck of femur in building good standards of nutrition. The initiative had been trialled at another hospital and assistant was working with dietitians to build better menu choices and calorie monitoring to support patients.

The interventional radiology team worked as part of a regional team across multiple trusts and hospitals. They were coordinating a recruitment programme for specialist nurses to address a London-wide shortage. This was part of a broader plan to improve capacity, access, and flow and the team were working to achieve admitting powers for radiologists. This would reduce delays caused by waiting for a consultant for emergency admissions, particularly for patients cared for on cancer pathways.

Ealing Hospital

Uxbridge Road
Southall
UB1 3HU
Tel: 02089675000
www.lnwh.nhs.uk

Description of this hospital

Ealing Hospital serves an ethnically diverse population mainly in the London Borough of Ealing. Ealing hospital provides the following services:

•Urgent and emergency care

•Medical care (including older peoples care)

•Surgery

•Outpatients and diagnostics

•Critical care

•End of life care

•Children's and young people services

We inspected medical care and surgery core services at our inspection on 9, 10 and 11 February 2022.

Medical care at Ealing Hospital was last inspected in August 2018 when it was rated and inadequate for safe and requires improvement for effective, caring, responsive and well led. Medical care was rated as requires improvement overall. A follow up inspection of medical care services was carried out in January 2019 but the rating was not reviewed because of the limited focus of the inspection.

At this inspection our overall rating of medical care stayed the same. We rated the service overall as requires improvement. We rated safe, responsive and well led as requires improvement and effective and caring as good.

During our inspection in February 2022 we visited seven integrated medicine division wards, and the ambulatory care unit, and the discharge lounge.

Our findings

Medical services involve assessment, diagnosis and treatment of adults by means of medical interventions rather than surgery. Medical care at Ealing Hospital provided care and treatment in the following disciplines: stroke; care of the elderly; cardiology; dermatology; genitourinary medicine (GUM) and sexual health; infectious disease; respiratory; rheumatology; endocrinology and diabetes; neurology and gastroenterology.

The number of admissions for the three specialties most admitted to in the division of integrated medicine at Ealing Hospital between 1 November and 31 January 2022 were : general internal medicine (GIM), with 1039 admissions in the period or 83% of total admissions; cardiology with 120 admissions, or 10% of total admissions in the period; and geriatric medicine with 30 admissions, or 2% of total admissions in the period.

Gastroenterology was not part of the integrated medicines division; it was a specialty in the St Mark's division. In the period 1 November to 31 January 2022 there had been 581 admissions in gastroenterology.

We spoke with eight patients and one relative. We reviewed 10 sets of patient records. We also spoke with 28 members of staff, including qualified nurses, matrons, consultants, doctors, senior managers, and support staff.

We rated medical care at Ealing Hospital requires improvement overall because:

- The service did not always have enough nursing and support staff to keep patients safe. The service was mitigating the staffing risks during twice daily safety huddles. However, there was a 22% vacancy rate for band 5 nurses.
- We found a drawer in the catheterization labs with a range of out of date equipment and a monitor in the catheterization labs which did not have a servicing date. We also found out of date equipment on a resuscitation trolley in the acute medical unit (AMU). There was a risk that staff could inadvertently use out of date equipment.
- On Ward 6 South, we found discrepancies in the use of Waterlow scoring. This is a tool used for pressure area risk assessment. This meant that patients' level of risk of developing pressure ulcers may not be accurately assessed and timely actions taken.
- Medical staff mandatory training in resuscitation was 72.2%. This was less than the 80% standard. This meant some staff may not have up to date skills in resuscitation.
- There was a lack of seamless services between the trust and other NHS providers of mental health care for patients temporarily on an acute ward waiting for transfer to a mental health facility. There was a risk of delays in patients care and treatment as a result of a lack of clarity about the responsibility for clinical decision making whilst the patient was an inpatient in the acute hospital.
- Due to a shortage of registered mental health nurses, the service had a policy of cohorting patients assessed as requiring enhanced observations or one to one care in a bay. However, we saw cohorted bays were not always observed by staff. There was a risk to patients if they were assessed as requiring enhanced observations or one to one care and this was not provided in accordance with their assessed needs at all times.
- The patient electronic record could only display a maximum of two patient needs on screen. This had led to staff not placing a magnetic identifier for the confusion care pathway above a patient's bed. The lack of a visual prompt for staff led to a patient not receiving a scheduled review after 72 hours. There was a risk that without a visual prompt, staff working on the bay may not be aware of patients' needs, unless they fully consulted patients' electronic records.
- Records were not always stored securely. We found a patient's 'adult inpatient care needs assessment' booklet next to the reception area in the acute medical unit (AMU). We saw a computer in the endoscopy reception which was unattended and not locked. There was a risk that unauthorised people could have accessed confidential patient information.

Our findings

- Staff told us the trust's senior executive team and some ward leaders were not visible at Ealing Hospital, as they were based off-site at Northwick Park Hospital.
- The signage enabling patients and visitors to navigate around the hospital was confusing for patients and visitors.
- Staff on the Older Persons Short Stay Unit (OPSSU) were using a printed copy of the infection prevention and control policy. There was a risk that staff may use an out of date policy instead of using the most up to date policies on the trust's intranet.
- We saw a cracked shower chair and shower chairs with chipped enamel on the OPPSSU. This could pose a patient safety and infection control risk as microorganisms can thrive in cracked surfaces.
- Domestic staff on the acute medical unit (AMU) was not aware of control of substances hazardous to health regulations (COSHH), including the trust's policies and guidance on COSHH.
- The trust was a large provider of cancer services but staff told us they did not have a local cancer strategy. This meant there was a potential risk that cancer services were not aligned to local commissioning and provision of services to support people during and after their cancer treatment.

However:

- The service managed safety incidents well and lessons were learnt from them.
- Staff gave patients enough to eat and drink and gave them pain relief when they needed it.
- Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to information.
- Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to raise complaints.
- Staff understood the service's vision and values, and how to apply them in their work and all staff were committed to improving services continually.

Surgery at Ealing Hospital was last inspected in August 2018 when it was rated requires improvement in safe, effective, responsive and well led and good in caring. Surgery was rated as requires improvement overall.

At this inspection our overall rating of surgery improved. We rated the service overall as good. We rated safe, effective, caring, well led as good and responsive as requires improvement.

We visited theatres, inpatient surgical wards, the theatre recovery unit and surgical assessment units.

Our findings

To manage staffing and capacity during the COVID-19 pandemic, the trust had restructured surgical services and treatment pathways. Ealing Hospital provided elective surgery and patients underwent pre-assessment care at Central Middlesex Hospital. As part of our inspection of surgical care at Ealing Hospital and Northwick Park Hospital, we visited Central Middlesex Hospital to understand the pre-assessment pathway and the post-treatment therapy provided by allied health professionals. We have included the findings in this inspection report.

We rated surgery at Ealing Hospital good overall because:

- The service had enough staff to care for patients and keep them safe. Staff had training in key skills, understood how to protect patients from abuse, and managed safety well. The service controlled infection risk well. Staff assessed risks to patients, acted on them and kept good care records. They managed medicines well. The service managed safety incidents well and learned lessons from them.
- Staff provided good care and treatment, gave patients enough to eat and drink, and gave them pain relief when they needed it. Managers monitored the effectiveness of the service and made sure staff were competent. Staff worked well together for the benefit of patients, advised them on how to lead healthier lives, supported them to make decisions about their care, and had access to good information. Key services were available seven days a week.
- Staff treated patients with compassion and kindness, respected their privacy and dignity, took account of their individual needs, and helped them understand their conditions. They provided emotional support to patients, families and carers.
- The service planned care to meet the needs of local people, took account of patients' individual needs, and made it easy for people to give feedback. People could access the service when they needed it and did not have to wait too long for treatment.
- Leaders ran services well using reliable information systems and supported staff to develop their skills. Staff were clear about their roles and accountabilities. The service engaged well with patients and the community to plan and manage services and all staff were committed to improving services continually.

However:

- The service was not fully compliant with DHSC Health Technical Memorandum 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste.
- The service had persistently high vacancy rates. At the time of our inspection the service had vacancies for 36 whole time equivalent (WTE) nurses. However, the number of nurses and healthcare assistants matched the planned numbers and vacancies were filled with bank and agency staff.

Surgery

Good ↑

Is the service safe?

Good ↑

Our rating of safe improved. We rated it as good.

Mandatory training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. At the time of our inspection 92% of staff were up to date with mandatory training.

Mandatory training was detailed and met the needs of patients and staff. Staff spoke positively about training access and content and practice development nurses support module delivery.

Clinical staff completed training on recognising and responding to patients with mental health needs, learning disabilities, autism and dementia.

Managers monitored mandatory training and alerted staff when they needed to update their training. Training compliance was a standing agenda item on team meetings and managers monitored completion rates weekly.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Staff received training specific for their role on how to recognise and report abuse. Overall compliance for medical and nursing staff for safeguarding 1, 2 and 3 was 98.6%. Staff were able to give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Nurses and allied health professionals (AHPs) said the safeguarding lead was visible and accessible and they worked well together to plan care, such as for complex discharges.

Staff knew how to make a safeguarding referral and who to inform if they had concerns.

Staff followed safe procedures for children visiting the ward. They completed specific risk assessments in such instances and alerted the safeguarding lead or safeguarding lead on admission.

Cleanliness, infection control and hygiene

The service controlled infection risks well. The service used systems to identify and prevent surgical site infections. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Surgery

Clinical areas were visibly clean and had suitable furnishings which were clean and well-maintained. Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned.

The service performed well for cleanliness. The infection prevention and control (IPC) team carried out monthly audits of wards and theatres, including hand hygiene and environmental cleanliness checks. Clinical managers maintained a continual oversight of this data through ward audits. We viewed the audits from wards and theatres which showed generally showed good compliance in areas assessed which included cleanliness of the clinical area, clear infection control signage equipment, use of personal protective equipment and '5 moments of hand hygiene'. Any areas requiring action was listed at the end of the audit with a responsible lead allocated and a progress/completion date section.

Staff used records to identify how well the service prevented infections. They also followed infection control principles including the use of personal protective equipment (PPE).

Staff worked effectively to prevent, identify and treat surgical site infections.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment kept people safe. Staff were trained to use them. Staff managed clinical waste well.

Patients could reach call bells and we saw staff responded to them quickly when called.

The design of the environment followed national guidance such as Department of Health and Social Care (DHSC) standards.

Staff carried out daily safety checks of specialist equipment and documented checks for tracking and auditing.

The service had enough suitable equipment to help them to safely care for patients.

Staff disposed of clinical waste safely. The trust managed waste streaming, including the storage and disposal of hazardous waste, in line with DHSC Health Technical Memorandum 07/01 (2013) in relation to the safe management and disposal of healthcare waste.

The service was not fully compliant with DHSC Health Technical Memorandum 07/01 and the Health and Safety Executive Health and Safety (Sharps Instruments in Healthcare) Regulations 2013 in relation to sharps waste.

Each ward and clinical area had a resuscitation trolley. This included a defibrillator, airway equipment of different sizes, and emergency medicines. Staff documented daily and weekly safety and security checks.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. Staff used the national early warning system (NEWS2) to monitor patients for clinical deterioration. They used an escalation process that ensured the critical care outreach team became involved in the care of patients who needed specialist, urgent input. The most recent audit demonstrated 100% compliance with documentation and appropriate escalation.

Surgery

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident, which resulted in a change in risk.

Surgical preassessment took place between two and four weeks prior to an operation and a nursing team led this at Central Middlesex Hospital. An on-site medical team provided care in the event a patient became unwell or deteriorated during the process.

Staff knew about and dealt with any specific risk issues. They assessed patients appropriately for sepsis, venous thromboembolism (VTE), falls and pressure ulcers. Staff documented learning from past incidents relating to VTE medicines stopped too early after the patient was discharged to the community.

Staff followed the World Health Organisation (WHO) five steps to surgical safety checklist for each procedure in theatres. The trust audited standards of checklist performance monthly and staff demonstrated consistently good levels of practice. The most recent audit reflected 100% compliance with the checklist overall and 93% compliance with the brief and debrief requirement.

Staff demonstrated knowledge of sepsis signs and risks and understood the sepsis pathway.

The service had 24-hour access to mental health liaison and specialist mental health support if staff were concerned about a patient's mental health.

Staff shared key information to keep patients safe when handing over their care to others. A multidisciplinary team including musculoskeletal therapists, medics, and surgeons held a daily trauma meeting to review overnight admissions. This ensured patients had an early review to plan their care. Physiotherapists used the process to plan immediate care for patients who were expected into theatre overnight but were unable to undergo their procedure.

Staff implemented risk assessments to manage care when patients were discharged to community partners. For example, the nutrition and dietetics team identified a risk caused by differences in the feed products used between the hospital and community teams. They discharged each patient with a seven-day supply of the feed they received in hospital to ensure a smoother transition to community care.

Shift changes and handovers included all necessary key information to keep patients safe. Multidisciplinary staff attended handovers, including ad-hoc external specialists such as community social workers, where this was in the best interests of a patient.

Nurse staffing

The service had enough nursing, allied health professional, and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction.

The service had enough nursing and support staff to keep patients safe. Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance.

Clinical managers could adjust staffing levels daily according to the needs of patients. Healthcare assistants and therapy assistant practitioners supported clinical teams across surgery services.

Surgery

The number of nurses and healthcare assistants matched the planned numbers and vacancies were filled with bank and agency staff.

The service had persistently high vacancy rates. At the time of our inspection the service had vacancies for 36 whole time equivalent (WTE) nurses. At the time of inspection the vacancy rate was 12%.

Managers made sure all bank and agency staff had a full induction and understood the service.

AHPs worked across the trust's hospitals and provided care and treatment to patients in a range of surgical settings. Physiotherapists and occupational therapists were organised into specific teams that covered orthopaedics, neurosurgery, respiratory medicines, and care of the elderly.

A team of 30 provided the speech and language therapy service across the trust, including at Northwick Park Hospital. The team had two vacancies and although this would bring the team to full establishment, demand persistently exceeded capacity.

Nursing and AHP teams utilised insourcing and outsourcing to help secure full staffing establishments.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

The service had enough medical staff to keep patients safe. The service always had senior consultant cover available on site. There was a gap in on-site anaesthetist cover daily between 6pm and 8pm and an on-call anaesthetist from another hospital in the trust provided cover. The senior team were recruiting to fill this gap.

The medical staff matched the planned number and doctors from other NHS trusts provided rota support through service level agreements.

Managers could access locums when they needed additional medical staff. They made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly.

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up to date, stored securely and easily available to all staff providing care.

Patient notes were clear and detailed, and all staff could access them easily. Elective preassessment took place off site, at Central Middlesex Hospital. We reviewed notes at both locations and found good standards of continuity, including detailed medical history, referral information, and microbiology results. Staff documented individual risk assessments and documented specific risks and needs relating to dementia and mental cognition.

Surgery

When patients transferred to a new team, there were no delays in staff accessing their records. The AHP team used an integrated electronic records system with community teams. This meant hospital therapists and community therapists had access to shared notes, which streamlined care planning. The physiotherapy team based at Central Middlesex Hospital provided post-surgical rehabilitation for patients treated at Ealing Hospital. This team used multiple records systems to coordinate and document care, including the electronic integrated system.

AHPs audited patient records for compliance with best practice standards.

Records were stored securely with locked access for paper records and encryption for digital records.

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes to prescribe and administer medicines safely. Patients' medicines were regularly reviewed and staff provided advice to patients and carers about their medicines.

Staff completed medicines records accurately and kept them up to date. Medicines were stored, managed and prescribed safely. Documents had been completed to the required standard.

Staff followed national practice to check patients had the correct medicines when they were admitted, or they moved between services.

Staff learned from safety alerts and incidents to improve practice.

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support. Managers ensured that actions from patient safety alerts were implemented and monitored.

Staff knew what incidents to report and how to report them. In the previous 12 months, staff reported 1298 incidents, of which 1154 were clinical incidents. Clinical ward managers used weekly quality checks to ensure staff received feedback and outcomes from recent complaints.

Staff raised concerns and reported incidents and near misses in line with trust policy.

The senior leadership team reviewed incidents to identify trends and themes. A divisional manager noted a key incident theme was overrunning theatre lists. For example, in December 2021, six surgeries extended for over 15 hours. Clinical and leadership teams were working together to identify the causes of such instances, which had increased in frequency.

Staff reported serious incidents clearly and in line with trust policy.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation when things went wrong. Staff documented evidence of how they used the duty of candour in the incident reporting system.

Staff received feedback from managers in relation to investigation of incidents, both internal and external to the service.

Surgery

Staff met to discuss the feedback and look at improvements to patient care. Clinicians took part in a monthly clinical governance day and used this forum to review incidents.

There was evidence that changes had been made as a result of feedback. Rehabilitation AHPs introduced a new standard operating procedures (SOP) for orthopaedic and respiratory patients cared for as outliers on medical wards. The team recognised outlier patients often did not receive the same standard of care and the SOP improved base skills for ward staff and introduced an escalation pathway to obtain therapeutic support for patients more quickly.

Managers investigated incidents thoroughly. Patients and their families were involved in these investigations. Managers debriefed and supported staff after any serious incident.

Is the service effective?

Good 

Our rating of effective improved. We rated it as good.

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance.

Audit nurses worked within the practice development team and supported staff across the division to engage in learning, monitoring, and improvement.

Day case surgery staff assessed standards of care using the standards of the British Association of Day Surgery. The most recent audit took place in October 2021 and staff scored the service 76% compliance.

Specialist allied health professionals (AHPs) used standard operating procedures to guide specific care pathways such as hand therapy. This enabled the team to provide structured and comprehensive care.

At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers.

Trauma coordinators worked with the AHP team to ensure trauma and orthopaedic patients admitted as outliers to medical wards received appropriate prescriptions and rehabilitation therapy. The team contributed monitoring data to the Trauma Audit and Research Network (TARN), which helped to benchmark best practice.

The AHP team used the national Chelsea Critical Care Physical Assessment Tool (CPAx) to measure outcomes as part of a regional strategy to benchmark post-surgical rehabilitation standards. This helped the team refer patients to specialist teams that would improve functional skills at home.

Surgery

Divisional and clinical leadership teams monitored a programme of rolling audits, including those designed to benchmark standards and results against standards set by the National Institute of Health and Care Excellence (NICE).

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. Staff followed national guidelines to make sure patients fasting before surgery were not without food for long periods. The service made adjustments for patients' religious, cultural and other needs.

Staff made sure patients had enough to eat and drink including those with specialist nutrition and hydration needs.

Dietitians had increased joint working with ward teams to improve feeding support and mealtime experiences. They trained volunteers to provide one-to-one support for patients and attended wards at mealtimes to provide spot training for nurses.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. They used a nationally recognised screening tool to monitor patients at risk of malnutrition.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. Staff worked across multidisciplinary departments to provide patients with the safest and most nutritious diet plans during their recovery. For example, dietitians and speech and language therapists planned diets with the catering team.

Patients waiting to have surgery were not left nil by mouth for long periods.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff used an intentional rounding process to monitor patients for pain and discomfort.

Multidisciplinary teams delivered pain management, such as joint working between pain nurses and physiotherapists during rehabilitation.

Patients we spoke to told us they received pain relief soon after requesting it. We saw that staff prescribed patient-controlled analgesia (PCA) where this was in the patient's best interests and used 'as-needed' (PRN) protocols to help manage pain effectively.

Medicines were prescribed safely and were administered according to patient prescription. The effectiveness of medicines was recorded. Staff documented pain management in each patient's care plan.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients. The service had been accredited under relevant clinical accreditation schemes.

Surgery

The service participated in relevant national clinical audits. Divisional and clinical leadership teams monitored a programme of rolling audits, including those designed to benchmark standards and results against standards set by the National Institute of Health and Care Excellence (NICE). An action plan dashboard tracked the actions against the audits undertaken. Submission rates of audits were monitored monthly using the trust wide national clinical audit exception report. For the year 2020-2021 Ealing Hospital participated in 98% (49/50) of national clinical audits.

Allied health professionals (AHPs) used standard outcome measures during care and therapy delivery. The measures varied across each AHP specialty based on each patient's rehabilitation care plan and staff tailored these to each patient's needs and preferences.

Outcomes for patients were positive, consistent and met expectations, such as national standards set by organisations such as the Trauma Audit and Research Network (TARN) and the Royal College of Occupational Therapists.

The speech and language therapy team had extended their scope of practice on inpatient wards to improve swallowing therapy outcomes through an endoscopy service. For example, the team offered fluroendoscope examinations.

AHPs used post-surgical questionnaires to help patients establish their own outcomes. This meant patients chose daily activities important to them, such as cooking a meal or doing laundry, which staff used as goals for therapy.

Interventional radiology was based at Northwick Park Hospital, which reflected patient need. The team provided an on-call service for Ealing Hospital.

Managers and staff carried out a programme of repeated audits to check improvement over time. They used information from the audits to improve care and treatment. AHPs based audits on patient-defined outcomes. Therapists worked with patients to understand their goals and aims from surgery and prepared therapy plans to help achieve them.

The acute podiatry team had restructured their service to improve patient outcomes. They had secured commissioning for four treatment pods on surgical wards across the trust, which enabled the team to deliver care on wards for the first time. The team established care pathways with physiotherapists and outpatients teams to help implement podiatry care as part of discharge plans.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients.

Managers gave all new staff a full induction tailored to their role before they started work.

Managers supported staff to develop through yearly, constructive appraisals of their work. Senior staff used this process to support continuing professional development and to offer wellbeing support. At the time of our inspection 91% of staff were up to date with appraisals.

Managers supported staff to develop through regular, constructive clinical supervision of their work.

Practice development nurses were assigned to each clinical department, such as theatres and critical care. The team supported the learning and development needs of staff, such as by providing ad-hoc teaching sessions during the delivery of care.

Managers made sure staff attended team meetings or had access to full notes when they could not attend.

Managers identified any training needs their staff had and gave them the time and opportunity to develop their skills and knowledge. Staff told us they had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge.

The speech and language therapy lead had implemented a plan to upskill therapists in the head and neck specialty. This provided opportunities to establish a baseline level of competency in the team that would help meet increasing demand.

Clinical nurse specialists worked across services to provide specialist support and upskilling. For example, head and neck clinical nurse specialists worked with inpatient ward staff to provide specialist care to patients with a tracheotomy or laryngectomy.

The divisional senior leadership team had implemented a human factor training programme using the international 'human, organisational, technical' (HOT) model. The multidisciplinary theatres team were taking part as part of a strategy to identify theatre dynamics in order to reduce incidents.

AHPs increased the range of specialist rotations available to increase training opportunities. They implemented new rotations into critical care, palliative care, and frailty services.

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings to discuss patients and improve their care.

AHP teams worked across multidisciplinary teams, roles, and hospitals. They worked with community and local authority teams and provided care to patients of other NHS trusts through service level agreements. This meant patients with complex needs, such as relating to stroke or a spinal injury, received coordinated care. Nurse specialists worked together to plan and coordinate care across clinical specialties, including with nurses who worked outside of the trust, such as cancer specialists. This included tissue viability nurses, pain nurses, cancer nurses, and stoma nurses.

The trust operated a range of multidisciplinary forums represented by staff across surgical specialties and wider services. For example, staff from ear, nose, and throat (ENT), gastroenterology, and speech and language therapy held multidisciplinary meetings to review patients who presented with complex swallowing issues. The forum allowed staff to review patient medical history in more detail and ensure they were offered the most appropriate care pathways. Staff extended forums to colleagues in other trusts. For example, patients who suffered a spinal injury were treated jointly by this trust and a specialist trust. Staff adopted an on-demand multidisciplinary approach to promote learning and development.

Surgery

Staff worked across health care disciplines and with other agencies when required to care for patients. The AHP team had introduced a 'beyond professional boundaries' programme to promote upskilling across specialties. This was a proactive approach to improving patient care and flow through the hospital by incorporating more flexible working between the trust's sites.

Staff referred patients for mental health assessments when they showed signs of mental ill health, depression.

Nurses and AHPs worked together during the pre-assessment phase of care to carry out a 'prehabilitation' assessment. This was part of an externally funded programme to provide more detailed planning for colorectal surgery patients. Tissue viability nurses and cancer nurses supported the physiotherapy team with this initiative.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients are reviewed by consultants depending on the care pathway.

AHP specialists in respiratory therapy and post-operative rehabilitation maintained a seven-day service to patients on wards. The service was planning to recommence a seven-day orthopaedic therapy service after a pandemic-related suspension.

Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used agreed personalised measures that limit patients' liberty.

Staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff gained consent from patients for their care and treatment in line with legislation and guidance. We saw consistent standards of consent obtained and documented at each stage of treatment, including from the preassessment stage.

Staff gained consent from patients for their care and treatment in line with legislation and guidance. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions.

Staff made sure patients consented to treatment based on all the information available.

Surgery

Staff clearly recorded consent in the patients' records.

Staff understood Gillick Competence and Fraser Guidelines and supported children who wished to make decisions about their treatment. They knew who to contact for support when providing care for patients with complex needs.

Staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards.

Staff understood the relevant consent and decision-making requirements of legislation and guidance, including the Mental Health Act, Mental Capacity Act 2005 and the Children Acts 1989 and 2004 and they knew who to contact for advice.

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards.

Is the service caring?

Good 

Our rating of caring stayed the same. We rated it as good.

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We observed compassionate and empowering conversations between staff and patients. In one example a physiotherapist encouraged a patient in their rehabilitation session to push their ability to walk up a flight of stairs. The member of staff had an empowering approach without applying pressure or stress to the patient.

We saw the staff followed policy to keep patient care and treatment confidential such as ensuring curtains were drawn during private conversations.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs. Staff acknowledged dedicated mental health support across the trust was limited and had established multidisciplinary pathways to help alleviate this risk. A psychologist worked in critical care and discharge teams liaised with them to plan safe discharges for patients with increased social risks. This was a comprehensive process and staff worked to establish social risks at home and understand more about their circumstances before they were admitted to hospital.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. Care plans we viewed reflected the individual needs of patients and we saw staff following these.

Surgery

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations. We observed staff interact with patients with kindness and understanding, including a calm manner, a smile, and positive eye contact.

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them. The preassessment team worked with patients to understand their worries and anxiety about surgery and provided reassurance and support.

Understanding and involvement of patients and those close to them

Staff supported and involved patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. Multidisciplinary staff worked with patients with complex needs to ensure they had adequate support at home after discharge. Occupational therapists led this process and worked with clinical commissioning groups (CCGs) to secure at home help for patients discharged with a stoma in place.

Staff talked with patients, families and carers in a way they could understand, using communication aids where necessary.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this.

Staff supported patients to make informed decisions about their care. We observed preassessment staff lead comprehensive and interactive conversations with patients. The team was skilled in ensuring patients gave information important for planning safe treatment and ensured patients contacted their GP when their needs changed.

Patients gave positive feedback about the service. Staff encouraged patients to participate in the NHS Friends and Family Test (FFT). In the previous 12 months surgery services performed consistently well, with 97% satisfaction rate.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Surgery

Service delivery to meet the needs of local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Managers planned and organised services, so they met the needs of the local population.

Allied health professionals (AHPs) worked across the trust's sites to deliver specialist care to patients. This included physiotherapists with specialist training in respiratory care and neurology care.

The senior leadership team noted that while theatre utilisation rates increased, patients required longer and more intensive post-operative therapy. This reflected extended waits for surgical treatment, which meant recovery was longer and more complex. The team demonstrated a deep understanding of how this impacted patient care and experience and incorporated it into care planning.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach.

Facilities and premises were appropriate for the services being delivered. Allied health professionals typically delivered rehabilitative care on inpatient wards and had access to a physiotherapy gym.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia.

The service had systems to help care for patients in need of additional support or specialist intervention. Staff across multiple specialties noted patients presented with more intensive clinical needs and more serious health problems because of the length of time they had waited to be seen during the pandemic. Staff worked together to enhance care and recovery pathways for these patients.

Managers monitored and took action to minimise missed appointments. During COVID-19 access restrictions, the allied health professional (AHP) team moved to a telehealth system that enabled them to maintain services to patients. This included joint consultations with speech and language therapy (SaLT) and a consultant to ensure patients maintained their full recovery care. The SaLT team recognised not all patients could access or benefit from telehealth and they worked to identify groups for whom it would be most beneficial.

Managers ensured that patients who did not attend appointments were contacted to check on their wellbeing.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs and this was set out in individualised care plans.

Staff supported patients living with dementia and learning disabilities by using 'This is me' documents and patient passports.

Surgery

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss.

The service had information leaflets available in languages spoken by the patients and local community.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed.

Patients were given a choice of food and drink to meet their cultural and religious preferences.

Staff had access to communication aids to help patients become partners in their care and treatment.

Access and flow

The trust was not meeting the referral to treatment national standard but had a recovery plan in place and was working jointly with the ICS to focus on achieving pre-COVID-19 activity levels.

The trust had restructured surgical services during the pandemic and this hospital offered elective surgery. The service benchmarked their average length of stay against other trusts nationally. The average length of stay for general surgery in the last six months was five days which was higher than the national average of 2.3 days. Between September 2021 and March 2022 the theatre cancellation rate for surgery was 13% (159 patients of 1227 procedures booked).

A nurse team carried out surgery preassessments for elective procedures at Central Middlesex Hospital. The team carried out electrocardiograms (ECGs) and blood tests at pre-planned times before a surgical procedure, which took place at Ealing Hospital. The trust separated these processes during COVID-19 pressures to reduce the risk of infection and preassessment operated seven days a week with up to 100 patients per day.

Managers and staff worked to make sure patients did not stay longer than they needed to. The senior team had updated the pre-assessment process as a strategy to reduce avoidable procedure cancellations. The new approach included a review of how the team validated surgical lists, a pre-assessment wellness check with the patient, and a medicines review to ensure they had followed pre-surgical instructions.

The trust was not meeting the referral to treatment (RTT) national standard of 92%, In February 2022 this was 69.2% with 397 patients waiting 52 weeks. The trust ranked 10th out of 18 London acute trusts. The trust had a recovery programme working jointly with the ICS to focus on recovering to pre-COVID-19 activity levels.

The trust reported cancer waiting times as a single organisation rather than by site. Between June 2021 and December 2022, for all two week waits, the trust achieved an average of 86% which did not meet the two week wait standard of 93%. As at January 2022, the trust ranked fifth out of 18 acute trusts and had met the standard 14 times out of the last 23 months.

The trust told us that this was due to a combination of factors including outpatient capacity for new and follow up patients caused by COVID-19 restrictions and staff sickness due to COVID-19. The trust has received funding to support additional waiting list initiatives which has helped to improve the backlog.

The trust met three of the six diagnosis standards in January 2022: 31 days decision to first treatment was reported at 100% (the target was 96%); 31 days decision to subsequent treatment (surgery) was reported at 100% (the target was 94%); 31 days decision to subsequent treatment (drugs) was reported at 100% (the target was 98%). The two week wait for suspected cancer was reported at 88.4% (the target was 93%); 2 week wait for breast symptoms was reported at

89.2% (the target was 93%); 28 day faster diagnosis was reported at 68.1% (the target was 75%). In response to this data, the trust had ensured that the straight to test pathways were strengthened and additional capacity arranged where possible in addition to ongoing staff recruitment. The trust also worked jointly with the sector to create further improvements to the cancer pathway to progress to the delivery of the national standards the Trust was meeting prior to the pandemic. The trust had agreed recovery trajectories for 2022/2023.

Managers made sure they had arrangements for surgical staff to review any surgical patients on non-surgical wards.

The service moved patients only when there was a clear medical reason or in their best interest.

Staff did not move patients between wards at night.

Managers and staff started planning each patient's discharge as early as possible. Clinical staff began the discharge planning process at the time of admission, which helped bed managers to work with clinical staff to plan reviews and care plans.

Staff planned patients' discharge carefully, particularly for those with complex mental health and social care needs.

Managers monitored the number of patients whose discharge was delayed, knew which wards had the most delays, and took action to reduce them.

Staff supported patients when they were referred or transferred between services. The trust has moved the extended care unit (ECU) to Central Middlesex Hospital as part of a bed restructure during the pandemic. The senior team worked with nurses to support appropriate redeployment to the hospital to ensure patients received safe care.

Managers monitored patient transfers and followed national standards.

Physiotherapists delivered post-surgical rehabilitation therapy to elective and trauma patients at multiple sites, including Central Middlesex Hospital (CMH). A rehabilitation gym was based at this hospital and physiotherapists demonstrated how they used it to support surgical patients. Patients selected the most convenient location and attended therapy pathway sessions. The Short-Term Assessment, Rehabilitation and Reablement Service (STARRS) team provided seven-day cover across the trust and between five and eight physiotherapists delivered care at CMH using bundles of care established before the patient was discharged.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns.

The service clearly displayed information about how to raise a concern in patient areas.

Staff understood the policy on complaints and knew how to handle them.

Managers investigated complaints and identified themes. The divisional leadership team reviewed complaints weekly as part of the clinical governance process.

Surgery

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint.

Managers shared feedback from complaints with staff and learning was used to improve the service. The trust monitored complaints for trends across surgery services. In the previous 12 months, surgery had received 180 complaints.

Complaints to the allied health professionals team were rare. The speech and language therapy team received one complaint in the previous 12 months. The team manager worked with the patient to understand the nature of the issue, which related to their perception of specialisms and training amongst the team. The manager identified opportunities for learning relating to how the trust manages patients who present frequently with complex needs.

Staff could give examples of how they used patient feedback to improve daily practice.

Is the service well-led?

Good  

Our rating of well-led improved. We rated it as good.

Leadership

Leaders had the skills and abilities to run the service. They understood and managed the priorities and issues the service faced. They were visible and approachable in the service for patients and staff. They supported staff to develop their skills and take on more senior roles.

The divisional triumvirate provided leadership for the surgery division across the three hospital sites. The triumvirate consisted of the divisional clinical director, director of nursing and the director of operations.

The division had four directorates. Each directorate was led by a general manager, a clinical director and a head of nursing.

The divisional and the directorate leadership oversaw the clinical, nursing and operational aspects of the service.

The divisional general manager worked across all three hospitals and was engaging with senior staff to understand how the leadership structure could be improved. This included the introduction of 'transformative meetings' within the triumvirate focused on effective day to day operational communications with the wider team.

Staff said leaders were friendly, approachable, and visible although said they felt turnover was high.

Vision and Strategy

The service did not have a coherent, overarching vision for what it wanted to achieve. Individual departments and divisions developed their own strategies in the absence of a trust-level approach. Staff were positive about local values and strategy.

Surgery

Senior staff described a divisional vision and strategy that was site specific and complemented the trust's corporate vision. The divisional leadership team recognised that while they worked between three different hospitals, each had its own unique properties. They worked with staff to ensure each hospital had its own identity, which would help to drive development following the pandemic. For example, the team recognised Ealing Hospital as an ambulatory care site and incorporated this into the trust's strategic direction.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

Staff who worked across multiple sites told us the system generally worked well and teams felt cohesive. The exception was amongst some senior managers who said they were spread too thinly across the trust to be able to make a meaningful impact.

Senior staff in some areas were concerned about the morale of their team. A senior therapy lead noted staff were, "…very tired at keeping going. They have no reserves left." They noted staff were continuing to deliver high standards of care and the trust had implemented a range of support packages.

Therapy leads introduced 'learning from excellence' awards to recognise and reward staff for going above and beyond during challenging pandemic working conditions.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

Governance processes were standardised across surgery services and included quality monitoring at ward, hospital, and trust levels. Staff in each clinical area used a quality board to monitor key performance indicators and help staff to take a role in local standards and practice.

The divisional leadership team prepared live tracking of theatre utilisation trends and patient throughput to provide assurances on service sustainability.

Divisional directors of operations and services met weekly with the senior trust team to establish priorities for the week ahead.

The senior clinical team organised monthly clinical governance days and staff representing specialties across the division took part. The events included training opportunities such as sessions delivered by equipment manufacturers.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

The trust had moved surgery resources and redeployed staff to critical care during the pandemic to meet patient demand. This meant the trust had to suspend the 24-hour national clinical national confidential enquiry into

perioperative deaths (CEPOD) surgical service and staff transferred patients to the Northwick Park Hospital for urgent treatment. CEPOD relates to emergency theatre lists during normal working hours. The trust had recently brought back the 24-hour service, which staff said meant they had reduced capacity to accept elective work. This was one of a number of complexities associated with the resumption of full capacity of care.

Matrons and ward managers from each of the trust's hospitals met with colleagues from medical services to hold joint safety briefings.

The service had reduced theatre utilisation during the pandemic and the senior team were in the process of returning to pre-pandemic levels. Senior divisional staff noted new nurse recruitment meant remaining theatre utilisation would return by April 2022.

The senior team described staffing, critical care capacity, and elective bed capacity as their most pressing challenges. The complexity of such issues meant there was a lack of capacity in the recovery unit, which the senior team had moved from critical care to a dedicated location. The senior team noted this issue was closely related to nurse vacancies and was an ongoing concern.

During all our discussions with staff it was evident work to stabilise staffing, service levels, and operational issues was well established, and teams were working well together to explore and establish new ways of working.

Surgical services had returned to 100% of pre-pandemic activity levels and the senior team were prioritising the restart of elective surgery. While activity levels had resumed, the team had a number of vacancies and senior staff were reviewing opportunities to improve working practices to meet demand.

Service leads and managers had a good understanding of the key risks to their teams and care delivery. Amongst AHPs, staff noted resilience of the team as a key risk due to the increasing demand, lack of capacity, and highly specialised nature of care needed.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

Clinical managers produced easily accessible audit and governance reports using the 'perfect ward' system, which staff used to monitor local data and drive improvements.

Multidisciplinary orthopaedic staff completed a project to improve post-operative patient documentation for patients with weight-bearing therapy needs. This reduced delays in rehabilitation care and improved discharge times.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

Some staff said they were unhappy with how integrated working with the trust's other hospitals was working and said there was a lack of consultation on decision-making processes.

Surgery

Therapy leads recognised differences in recruitment and retention between specialties. They arranged staff focus groups to understand the causes and address pressures and challenges in the team. Staff spoke positively about this and said they appreciated the level of engagement on their wellbeing.

While staff recognised the benefits of maintaining contact with patients using virtual means during the pandemic, they knew this was not an optimal approach for some patients. They audited adapted processes and found colorectal patients in particular preferred one-to-one rehabilitation after surgery. Staff used these findings to restructure virtual and in-person care.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The speech and language therapy (SaLT) lead recognised the increasing demand on voice and head and neck therapy as key pressure points, with significant gaps in qualified, trained specialists. They were working with student therapists to build a future workforce in these specialties by addressing gaps in practical exposure they typically receiving in training and placements.

Senior teams encouraged and supported innovation and shared this widely. For example, a SaLT therapist worked with a school outside of the UK to develop a new technique for reflex testing using endoscopic swallowing measures. Other trusts and international hospitals remained in contact with the team to understand best practice.

Therapy leads identified pressure on the occupational health service and carried out sustainability planning exercises, including more intensive exit interviews with departing staff. The team established relationships with two universities to provide training opportunities for students, which would result in more predictable future recruitment from graduates.

The dietetics team and gastroenterology surgery teams were working together to explore greater AHP involvement in pre-assessment processes with a view to improved patient outcomes. This was one example of a number of innovative projects established by individual teams to explore new ways of working to improve patient experience and outcomes.

Medical care (including older people's care)

Requires Improvement ➔➔

Is the service safe?

Requires Improvement ➔

Our rating of safe improved. We rated it as requires improvement.

Mandatory Training

The service provided mandatory training in key skills to all staff and made sure everyone completed it.

Staff received and kept up to date with their mandatory training. The trust's key performance indicator (KPI) dashboard recorded 87.3% compliance with mandatory training, which was better than the trust's 80% minimum standard and was an improvement since the last inspection.

Mandatory training included: conflict resolution; health and safety; infection prevention and control; information governance; manual handling; and fire safety. We found the overall mandatory training completion rate for nursing staff was 88.6%.

Medical staff received and kept up to date with their mandatory training. Medical staff were compliant with the trust's mandatory training minimum standard of 80%. The overall mandatory training rate for medical staff was 86.35%. The highest rates of compliance were staff in endocrinology at 92.79% and the lowest rate was staff in infectious diseases at 78.69%.

Basic life support (BLS) training was mandatory for nursing and medical staff. At the time of inspection 83.07% of nursing staff. This was within the trust's 80% minimum standard. However, we saw that 72.18% of medical staff had up to date BLS training. This meant there was a risk of some staff not having up to date skills in resuscitation.

Staff received a notification from the trust's learning and development team when training was due to be updated. Staff told us their line managers also received a notification to inform them when their training was due to be updated.

Safeguarding

Staff understood how to protect patients from abuse and the service worked well with other agencies to do so. Staff had training on how to recognise and report abuse and they knew how to apply it.

Safeguarding training was comprehensive and met the needs of patients and staff. Staff demonstrated understanding of the types of abuse people may experience. We saw information on how to report safeguarding was available on all wards we visited.

Staff received training specific for their role on how to recognise and report abuse. Following our inspection, we requested current compliance rates in accordance with intercollegiate document guidance. This provides a clear framework which identifies the level of safeguarding competencies required for all healthcare staff.

Medical staff had 84.9% compliance with level 2 safeguarding adults training. This met the trust's 80% minimum standard. Medical staff had 92.4% compliance with level 2 safeguarding children training. Medical staff also had 100% compliance with level 3 safeguarding children's training.

Nursing staff had 90% compliance with level 2 safeguarding adults training and 95% compliance with level 2 safeguarding children training. Nursing staff also had 95% compliance with safeguarding children level 3 training.

Staff received training in 'prevent'. This is training to aid staff in recognising people at risk of becoming involved in terrorism or extremist activity and is designed to safeguard people in a similar way to other safeguarding processes that protect people from modern day slavery or sexual abuse. Mandatory training figures for prevent training at the time of inspection were: 97.1% of nursing staff and 83.9% of medical staff.

Staff knew how to identify adults and children at risk of, or suffering, significant harm and worked with other agencies to protect them. Safeguarding training included modern day slavery, child sexual exploitation (CSE) and female genital mutilation (FGM). Staff demonstrated understanding of recognising the types of abuse patients may experience. Information on how to report safeguarding was available on all the wards we visited. Patients where safeguarding concerns were identified had risk assessments and care plans in place to manage safeguarding risks.

Staff could give examples of how to protect patients from harassment and discrimination, including those with protected characteristics under the Equality Act. For example, staff told us patients with safeguarding risks and sensory loss, or a language barrier would be offered face to face interpreting services.

Staff knew how to make a safeguarding referral and who to inform if they had concerns. The trust had a specialist safeguarding team. Staff told us if there were safeguarding concerns, they would liaise with the trust's safeguarding team. Staff were able to show us the contact details for both the trust's and local authority safeguarding teams. The trust had a dedicated safeguarding nurse on duty, 24 hours a day, seven days a week.

The trust had safeguarding vulnerable adults and children's policies and guidelines that provided staff with information on actions to take in the event of safeguarding concerns. Safeguarding information was readily available to staff on the trust's safeguarding team's intranet pages.

Cleanliness, infection control and hygiene

The service-controlled infection risk well. Staff used equipment and control measures to protect patients, themselves and others from infection. They kept equipment and the premises visibly clean.

Overall, ward areas were clean and had suitable furnishings which were clean and well-maintained. The ward areas were visibly clean. However, a ward manager told us there had been a reduction in the frequency of floors being buffed as a result of the COVID-19 pandemic. The ward manager said this made flooring look scuffed. Staff said they were not aware of any plans to reinstate buffing of the ward floors.

The integrated medicines division generally performed well for cleanliness. We viewed a divisional infection prevention and control audit dated October 2021. This recorded that three wards were partially compliant and improvement was required for the remaining four wards. Action plans were produced in response and monitored at monthly infection control meetings as part of divisional reporting. However, the report did not include the individual names of the wards, which meant CQC were unable to assess performance on individual wards.

We viewed hand hygiene audit data for January 2022 for wards: 4 South; 5 North; 6 North; 6 South; 8 South; and 9 North. All wards' hand hygiene had compliance above the trust's 90% standard for every week in the month, except for 9 North, which had one week where the compliance rate was 85%.This was below the trust's 90% standard.

At the time of inspection training rates for infection prevention and control were: 94.8% of nursing staff and 89% of medical staff had up to date training.

Cleaning records were up-to-date and demonstrated that all areas were cleaned regularly. We observed housekeeping staff cleaning the wards and in the departments during our inspection. We viewed cleaning records on the acute medical unit (AMU) and found these were complete and up to date.

Staff followed infection control principles including the use of personal protective equipment (PPE). Gloves, masks, aprons, and other PPE were readily available to staff. We saw staff observing the hospital's 'bare below the elbow' policy. Information for visitors on cleaning their hands was clearly displayed across the wards. This explained good hand washing technique and when visitors should clean their hands. We saw visitors washing their hands and using hand gels.

On the Older Persons Stay Unit (OPSSU), we found staff were using a printed copy of the trust infection prevention and control policy. There was a risk that staff may use an out of date policy instead of using the most up to date policies on the trust's intranet.

Staff cleaned equipment after patient contact and labelled equipment to show when it was last cleaned. Equipment that was shared between patients was cleaned after each use, labelled with a green 'I am clean' sticker and dated. We saw equipment across the wards labelled with high visibility 'I am clean' stickers, to assure staff that the equipment had been cleaned and was ready for use.

The trust's health and safety team had audited integrated medicines division COSHH practice in January 2021. The audit found 94% compliance across the wards and departments with an inventory of COSHH substances; and 100% compliance with wards and departments having COSHH risk assessments in place.

Cleaning services at Ealing Hospital were provided via a service level agreement with an external provider of cleaning services. However, when we asked domestic staff on the acute medical unit (AMU) about guidance relating to the control of substances hazardous to health (COSHH), they told us they did not know what COSHH was.

Environment and equipment

The design, maintenance and use of facilities, premises and equipment did not always keep people safe. However, staff were trained to use them. Staff managed clinical waste well.

Although, the design of the environment followed national guidance, we found the signage enabling patients and visitors to navigate around the hospital was confusing. For example, the signage for the endoscopy reception on level 2 was behind a set of double doors on the ground floor, which led to a lift. Patients on the ground floor corridor would not have seen the sign if they were on the main corridor.

Staff carried out daily safety checks of specialist equipment. However, we found a monitor in the catheterization labs which did not have a servicing date. Staff told us the monitor was on loan from the trust's electrical and biomedical engineering (EBME) department and EBME were responsible for servicing equipment. We also found a range of out of

date equipment stored in drawers in the catheterization lab, including: a flexible yankauer set, (surgical suction instrument), which had an expiry date of December 2021; a radial compression device with an expiry date of 2021. The drawers were untidy and stored in date equipment alongside out of date equipment. There was a risk that staff could inadvertently use out of date equipment.

The service did not always have suitable facilities to meet the needs of patients. For example, we saw a cracked shower chair and shower chairs with chipped enamel on the Older Persons Short-Stay Unit (OPPSSU). This could pose a patient safety and infection control risk as microorganisms can thrive in cracks in surfaces.

We found privacy curtains were clean and in-date. Patients could reach call bells and staff responded quickly when called.

We found the resuscitation trolley on the AMU had been checked daily and records were up to date. However, the trolley contained two pieces of equipment that had expired. This was highlighted to the nurse in charge and they removed the out of date items immediately.

The trust had a system for managing blood glucose meters which meant they could only be used if calibrated daily. We found disposable privacy curtains on bays were clean and in-date.

Staff disposed of clinical waste safely. Wards had appropriate facilities for domestic and clinical waste segregation. Disposable sharps bins were sealed, appropriately stored and labelled.

Assessing and responding to patient risk

Staff completed and updated risk assessments for each patient and removed or minimised risks. Staff identified and quickly acted upon patients at risk of deterioration.

Staff used a nationally recognised tool to identify deteriorating patients and escalated them appropriately. The trust used the National Early Warning Score (NEWS2). NEWS2 is based on a simple scoring system in which a score is allocated to physiological measurements when patients are being monitored in hospital to identify patients at risk of deterioration in their condition and ensure appropriate escalation in their care. Staff were aware of what actions to take if NEWS2 scores were higher than expected. We found NEWS2 record scores had been totalled correctly, and any concerns with NEWS2 scores were escalated. A snapshot audit of NEWS2 documentation found 100% compliance with the trust's key performance indicator (KPI) for NEWS2.

Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, including after any incident. We reviewed 10 patient admission booklet records. We found risk assessments were completed. However, we found discrepancies in the use of Waterlow scoring on ward 6 South. This meant that patients' level of risk of developing pressure ulcers may not be accurately assessed and timely actions taken to address the risk.

We reviewed results of the hospital's 'national audit of dementia care in general hospitals 2021'. The audit found 98% of patients living with dementia, totalling 46 of the 47 patients reviewed, had formal pressure ulcer risk assessments carried out and recorded. This was slightly better than the national average of 95.%.

Staff knew about and dealt with any specific risk issues. For example, we viewed audit data for the month of January 2022. This found that the integrated medicines division were not meeting the trust's 100% standard for Methicillin-resistant Staphylococcus aureus (MRSA) screening with an average rate of 96.33%. MRSA is a type of bacteria that is resistant to several widely used antibiotics. This means infections with MRSA can be harder to treat than other bacterial infections.

We viewed the trust's 'Guidelines for the Admission, Investigation & Management of Infectious Diseases at Northwick Park, Ealing, & Central Middlesex Hospitals, August 2021.' The guideline clearly identified the initial care and treatment of patients admitted to the hospital with a suspected infectious disease, including COVID-19. The guideline contained hyperlinks to national guidance and standards, such as, the public health England (PHE) guidance on 'the use of antiviral agents in treatment and prophylaxis of seasonal influenza', as well as guidelines for managing suspected sepsis in adults and young people aged 18 years and over.

The service had 24-hour access to mental health liaison and specialist mental health support (if staff were concerned about a patient's mental health). Staff completed, or arranged, psychosocial assessments and risk assessments for patients thought to be at risk of self-harm or suicide. However, staff told us there was a lack of seamless services between the trust and mental health trusts. Staff told us that there was often a lack of registered mental health nurses availability whilst a patient was receiving care in the acute hospital.

During the inspection we saw a patient experiencing a mental health crisis on the acute medical unit (AMU). The patient was fit for discharge to mental health services. Staff told us their staff were not trained to treat patients in mental health crisis. The patient's care and treatment were being managed by an NHS provider of mental health care. However, we witnessed delays to the patient's care and treatment while the staff on the ward and staff from other NHS providers liaised and discussed a plan of care for the patient. This was due to a lack of clarity about where the responsibility for the patients care lay and who was responsible for clinical decision making whilst the patient was an inpatient in the acute hospital.

Staff told us they had tried to employ an agency registered mental health nurse (RMN) to provide one to one care for the patient, but, there had not been any availability. The ward had a health care assistant (HCA) providing care to observe the patient. However, the HCA was also responsible for other patients that were cohorted on the bay. Staff told us the ward sometimes resorted to using security staff to manage patients that were experiencing a mental health crisis. Staff highlighted that challenging behaviour from patients in mental health crisis was also witnessed by other patients on the ward, and this had a negative impact on other patients' experience of the ward.

Furthermore, we viewed a serious incident report for another ward which involved a patient not receiving one to one care, even though the patient had been assessed as requiring this. There is a risk to patients if they are assessed as requiring enhanced observations and this is not provided in accordance with their assessed needs.

Shift changes and handovers included all necessary key information to keep patients safe. Upon admission, patients had a recommendation for which team would provide their care on a post-take ward round. This was entered onto the patient electronic record system and was available to the bed management team when they are allocated a bed. When there were insufficient medical care beds available, the patient might be placed in a surgical ward, 7 North, as an outlier.

The integrated medicines division had a handover every morning, Monday to Friday at 8.30am and Saturday and Sunday at 9am, via video conferencing where the consultant on-call for medicines reviewed and presented the admissions from the previous 24 hours. A member of each specialty medical team attended these meetings and the weekend medical team attended at weekends. This ensured medical teams were aware of any new admissions allocated to them, including any medical outliers.

In addition, all teams had a daily board round at 9am to ensure the ward manager and bed manager was aware of any outlying patients, and could arrange for them to be repatriated from the surgical ward back to the respective medical ward, if capacity and clinical priority-allowed. All patients saw a decision-making clinician for review during daily ward rounds. Outlier numbers were low at the time of inspection. The number of outliers was five on the 9 February 2022 and two on 10 February 2022.

Out of hours cover in the evenings, overnight and at weekends was provided by the on call medical team, led by the medical specialist registrar covering the wards. Handovers took place between day and night shifts, and sick medical patients on any ward, including outlying patients, were reviewed by the medical consultant on-call.

Nurse staffing

Managers regularly reviewed and adjusted staffing levels and skill mix, and gave bank and agency staff a full induction. However, the service did not always have enough nursing and support staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment.

The service did not always have enough nursing and support staff to keep patients safe. The service was mitigating the staffing risks during twice daily safety huddles and used bank and agency staff when required and clinical staff in non-clinical roles worked clinically if necessary. The huddles were attended by senior nursing staff from each ward and matrons.

The integrated medicines divisional risk register identified a staffing risk due to the lack of a specialist diabetes nurse at Ealing Hospital. In mitigation the trust were working with partner organizations in the North West London integrated care system (ICS) on a business case for the role, (ICS are partnerships between the organisations that meet health and care needs across an area, to coordinate services and to plan in a way that improves population health and reduce inequalities between different groups).

Managers accurately calculated and reviewed the number and grade of nurses, nursing assistants and healthcare assistants needed for each shift in accordance with national guidance. Nursing staffing levels were assessed using the National Safer Nursing Care Tool (SNCT). Managers and staff told us that, when there were nursing shortages on the roster, these would usually be made up from bank or agency staff. Staff worked flexibly across services. However, wards and departments frequently worked without the established number of nursing and healthcare assistant staff.

Staff in the catheterization labs told us the service did not use bank or agency staff. The service had recruited two band 6 staff that worked flexibly at both Ealing Hospital and Northwick Park Hospital.

Managers could adjust staffing levels daily according to the needs of patients. The integrated medicines division at Ealing Hospital ran twice daily safety huddles to review staffing. As a result of the daily safety huddle reviews, staff could

be asked to work flexibly and work in a different ward or department to cover staffing shortages. The safety huddle addressed staffing issues across the division. However, it meant when wards had their staff redeployed, the ward did not have their full establishment of staff. Managers told us the safety huddles were a way of managing and sharing staffing risks across the division.

The integrated medicines key performance indicator (KPI) dashboard dated January 2022 found that the average shift fill rate during the day was 82.7%. This was lower than the trust's 90% KPI standard. The rate improved at night when the average fill rate was 95.5%, which was better than the trust's 90% KPI standard. Managers told us staffing shifts on weekdays could be a challenge.

There were still high vacancy rates in elderly care. Managers told us the service were able to recruit to most specialties, but Ealing Hospital had struggled to fill vacancies in elderly care. Managers told us that, in line with national trends, it had been especially difficult to recruit band 5 nursing staff. For example, at the time of inspection the band 5 vacancy rate on ward 8 South was 42%. The average vacancy rate for nursing staff in integrated medicine by banding was as follows: band 2 (12.5%); band 3 (0%); band 4 (0%); band 5 (22%); band 6 (2%); band 7 (0%).

The trust informed us there were 11.86 WTE health care assistant vacancies across medical wards. However, it was expected that these would be fully recruited to by March 2022, as the trust had been successful in recruiting to these roles.

We requested information on the staff sickness rates. We were sent the divisional key performance indicator dashboard for January 2022. The rate in January 2022 was 8.6%, which was worse than the trust's 4% KPI standard. However, managers told us sickness rates had increased in January 2022 due to staff having positive COVID-19 tests and having to self-isolate.

We requested up to date information on the use of agency staff across the integrated medicines division. We received data for the period 17 January to 13 February 2022. During this period ward 4 South had 5.10% of total assigned working hours filled by agency staff; ward 5 North had 0.2% of assigned working hours filled by agency staff; ward 5 South had 1.1% of assigned working hours filled by agency staff; ward 6 South had 3.3% of assigned working hours filled by agency staff; ward 8 South had 10.2% assigned working hours filled by agency staff. However, the data referred to one month of assigned working hours filled by agency staff and may not be a reflection of the division's use of agency staff over a longer period.

Managers told us they limited their use of bank and agency staff and requested staff familiar with the service.

Managers made sure all bank and agency staff had a full induction and understood the service prior to commencing work on the wards.

The division had been involved in a cross-divisional project to employ ward based nutritional assistants to cover mealtimes Monday to Sunday on care of the elderly wards. This would be an apprenticeship role, at band 2 for the first 18 months, progressing to band 3. The intention was that the posts would improve patients' nutritional intake, clinical outcomes, patient flow, and support workforce challenges.

Medical staffing

The service had enough medical staff with the right qualifications, skills, training and experience to keep patients safe from avoidable harm and to provide the right care and treatment. Managers regularly reviewed and adjusted staffing levels and skill mix and gave locum staff a full induction.

Medical care (including older people's care)

The service had enough medical staff to keep patients safe. We reviewed data provided by the trust regarding the total number of medical staff broken down by grade, percentage of locum staff used for February 2022. We found there were enough medical staff across 11 of the 14 specialisms and medical staff matched the planned number, except for: older people's medicine, where the rate of locum use for consultants was 45.5%. The established consultant staffing was 6.6 WTE, this equated to three WTE locum consultants. We also found 50% junior doctors locum usage in older people's medicine. However, the established junior doctors were four WTE, hence this equated to two locum junior doctors. Neurology had a WTE of 2.7 consultants, the locum use rate was 22.2%, this equated to 0.6 WTE. Cardiology establishment was three WTE specialist registrars (SpR), the locum use rate was 33.33%, this equated to one WTE locum SpR.

The service had reducing vacancy rates for medical staff. Managers told us the service had enough junior doctors, but, found the recruitment of specialty registrars and registrars a challenge. At the time of inspection, the service was advertising five registrar roles.

We viewed data on medical staff vacancy rates dated 24 February 2022. There was 44.4% consultant vacancies and 50% vacancies for junior doctors in older people's medicines (DMOP); 33.3% specialist registrar vacancies in cardiology; and 50% specialist registrar vacancies in infectious diseases. The trust informed us a junior doctor had been recruited for older people's medicine

Managers could access locums when they needed additional medical staff. Managers made sure locums had a full induction to the service before they started work.

The service had a good skill mix of medical staff on each shift and reviewed this regularly. Medical staff had rotas and specialty rotas. Managers told us cover for inpatient rotas could be difficult and could require agency cover.

We saw a risk on the divisional risk register relating to imminent consultant geriatrician workforce depletion at Ealing Hospital. In response the risk register recorded that two locum consultants were in place to back fill the positions. The service was recruiting to the roles. However, the risk register recorded in February 2022 that the trust had not received any applicants that were suitable for these roles.

The risk register identified a risk at Ealing Hospital relating to specialist registrars in cardiac arrest, medical emergency team (MET) calls, and ward cover. The risk register identified the controls in place to mitigate the risk as: locum cover, backfilling shifts with senior house officers, and recruiting new staff to reduce the number of specialist registrar vacancies from five to three by April 2022.

The service always had a consultant on call during evenings and weekends. There was an on-call medical consultant available 24 hours a day, seven days a week. However, there was a risk on the risk register relating to specialist respiratory care on ward 6 South, due to a lack of respiratory consultant cover out of hours and at weekends. In mitigation staff from the intensive care unit (ITU) were offering support and a respiratory consultant post was being recruited to.

Medical care had a range of allied health professionals working on medical wards. The established assessed staffing needs were: 3.6 whole time equivalent (WTE) dietitians; eight WTE occupational therapists (OT). At the time of inspection there were four WTE vacancies for OT. Ealing hospital had six established WTE rehabilitation technicians (RT), with 1.5 WTE vacancies; the hospital had 13.7 WTE physiotherapists, with no physiotherapy vacancies; there were 3.1 WTE speech and language therapists (SLT), with no SLT vacancies at the time of inspection.

Medical care (including older people's care)

Records

Staff kept detailed records of patients' care and treatment. Records were clear, up-to-date, and easily available to all staff providing care. However, records were not always stored securely.

Patient notes were comprehensive, and all staff could access them easily. We examined nine sets of patient records and saw that documentation including venous thromboembolism (VTE) assessments, malnutrition universal screening tool and national early warning scores, and skin integrity charts were completed correctly in almost all cases. In two sets of notes on 8 South ward (COVID-19), Waterlow assessments had not had their scoring totals correctly calculated.

We reviewed 12 sets of patient records and saw that documentation including venous thromboembolism (VTE) assessments, malnutrition universal screening tool (MUST) and national early warning scores, and skin integrity charts were complete.

Two sets of notes we examined contained confusion care pathways, which are tools for supporting the care and treatment of patients with dementia or delirium. We found records had been reviewed by appropriate staff.

The service used an application (app) to monitor quality and safety. The app used a traffic light 'red, amber, green rated' (RAG) system of monitoring. We requested information on audits of the national early warning score (NEWS2). The trust returned data dated January 2022. In January 2022 we saw wards 4 South, 5 North and 5 South, 6 North and 6 South had a green RAG rating, having achieved 100% compliance in the month in use of the NEWS2. In the same audit ward 6 South had 97.6% compliance. However, 8 South was amber rated with 75% compliance in the same period.

There was a system of 'intentional rounding'. This was a structured approach which demonstrated patients had checks at set times to assess and manage their fundamental care needs. We found patients' records demonstrated staff regularly repositioned patients in accordance with their care needs; offered drinks; and assisted patients with their toileting needs.

When patients transferred to a new team, there were no delays in staff accessing their records. The service had introduced an assessment document, which contained information on patients' fundamental care needs and could travel with the patient if the patient was transferred.

Records were not always stored securely. We found a patient's 'adult inpatient care needs assessment' booklet which was on a set of filing cabinets next to the reception area in the acute medical unit (AMU). The reception area was unattended at the time. There were external building contractors working on the ward at the same time, which could have compromised the patient's confidentiality. We saw a computer in the endoscopy reception which was unattended and not locked. We also saw an unattended patient record on top of an open filing cabinet in cardiology. There was a risk of unauthorised people gaining access confidential patient information.

The patient electronic record could only display a maximum of two patient needs on screen. We reviewed a patients' electronic record and found four needs were hidden from the screen. This had led staff to staff not placing a magnetic identifier for the confusion care pathway above a patient's bed. The lack of a visual prompt for staff led to the patient not receiving a review after 72 hours, in accordance with the patient pathway. There was a risk that without a visual prompt, staff working on the bay may not be aware of patients' needs, unless they fully consulted the patients electronic record.

The trust's medical wards had suspended records audits during the COVID-19 pandemic. The trust informed CQC that records audits were part of the audit programme for 2022/23.

Medical care (including older people's care)

Medicines

The service used systems and processes to safely prescribe, administer, record and store medicines.

Staff followed systems and processes when safely prescribing, administering, recording and storing medicines.

Medicines (including controlled drugs) were stored in automated dispensing cabinets which enabled staff to track medicines use. Staff felt that automated dispensing cabinets had reduced the incidence of missed doses. However, staff also told us that they felt it sometimes delayed medicines administration.

Medicines advice and supply were available seven days a week. An on-call pharmacist was available outside of core working hours.

All prescription charts that we looked at included the allergy status of the patient.

Pharmacy staff on the ward accessed the electronic dispensary system. This enabled them to establish the location of a medicine and prevent unnecessary wastage.

We viewed the results of a monthly medicines management audit for January 2022. This recorded that the integrated medicines division did not meet the trust's standard of between 96% and 100% compliance. The score in January 2022 for medicines administration was 92.6%, This was due to two wards, 6 North with 90% compliance, this was worse than the trust's compliance standard; and 6 South with 60% compliance, this was much worse than the trust's compliance standard.

Staff reviewed patients' medicines regularly and provided specific advice to patients and carers about their medicines. All patients we reviewed at risk of venous thromboembolism (VTE) had an assessment for VTE and were prescribed the relevant medicines.

Staff stored and managed all medicines and prescribing documents in line with the provider's policy. We saw that medicines were stored in dedicated secure storage areas, and access to medicines was restricted to authorised staff.

A risk was identified on the divisional risk register relating to the safe storage of intravenous (IV) fluids on ward 6 South. Controls were in place to mitigate the risk, including staff not dispensing IV fluids from boxes; pharmacy staff transferring IV fluids to the automated dispensing cabinets prior to administration, and the company providing IV fluids reducing excess fluids being delivered to the ward. The risk had been discussed at the medication safety sub-group and quality and risk meeting on 24 November 2021. The decision was that, although there were controls in place, the risk remained, and the risk score would stay the same.

Staff followed current national practice to check patients had the correct medicines. Pharmacists checked what medicines the patient was taking, medicines reconciliation, and recorded the reason why a medicine was stopped, started, or a dose was changed.

The service had systems to ensure staff knew about safety alerts and incidents, so patients received their medicines safely. There had been 46 medicines incidents report on the trust's electronic incident reporting system in the previous 12 months. We viewed the medicines incidents dashboard and found there were no obvious themes and trends from these incidents. The highest reported rate of these incidents was six incident reports relating to medicines not having been administered.

Medical care (including older people's care)

Decision making processes were in place to ensure people's behaviour was not controlled by excessive and inappropriate use of medicines. Pharmacists told us that they made suggestions to prescribers to reduce unnecessary polypharmacy, (this is the use of five or more medications daily by an individual).

Incidents

The service managed patient safety incidents well. Staff recognised and reported incidents and near misses. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

All staff knew what incidents to report and how to report them. In the period 1 February 2021 to 31 January 2022, 1049 incidents were reported across the integrated medicine division. Data from the trust indicated that clinical incidents in the 'Implementation of care or ongoing monitoring/review' category were the most frequently reported on the trust's incident reporting system. These incidents included diabetes management, infection control, delay of failure to monitor, or tissue damage acquired during admission. Accidents that may have resulted in personal injury were the second highest category of clinical incident. This category included slips, trips and falls. The most frequently reported incident in this category were falls from a height, bed, or chair.

Staff raised concerns and reported incidents and near misses in line with trust policy.

Staff reported serious incidents clearly and in accordance with trust policy. Trustwide data from the strategic executive information system (STEIS) recorded that between 1 February 2021 and 31 January 2022 there had been eight serious incidents reported through the strategic executive information system (STEIS). This system is used to report and monitor the progress of serious incident investigations across the NHS. Four of these incidents involved slips, trips and falls; two involved delays in treatment; there was also one serious incident that involved medicines and one serious incident that had happened recently and was pending review at the time of inspection.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if things went wrong. We saw from a review of three root cause analysis (RCA) serious incident investigation reports that patients and families views were sought and outcomes of serious incident investigations were shared with them. Details of duty of candour discussions with patients and families were documented.

Staff received feedback from investigation of incidents, both internal and external to the service. We saw learning from an incident being fed back to staff during a handover meeting on the Older Persons Short-Stay Unit (OPPSSU). However, the learning was not clear and delivered in a way where it was obvious that these were the learning points staff should take away from the meeting.

Managers debriefed and supported staff after any serious incident. Serious incident investigation reports identified support provided to staff. For example, all the RCA serious incident reports we reviewed identified specific support offered to staff including the support of senior managers and the trust's occupational health team.

Is the service effective?

Good ↑

Our rating of effective improved. We rated it as good.

Medical care (including older people's care)

Evidence-based care and treatment

The service provided care and treatment based on national guidance and evidence-based practice. Managers checked to make sure staff followed guidance. Staff protected the rights of patients subject to the Mental Health Act 1983.

Staff followed up-to-date policies to plan and deliver high quality care according to best practice and national guidance. Guidance and best practice guidelines from the trust and the National Institute for Health and Care Excellence (NICE) were accessible to staff on the trust's intranet. Staff told us guidance was easy to access.

We viewed a selection of the trust's policies and procedures and saw these referenced legislation and guidance that underpinned the policy. For example, we viewed the trust's standard operating procedure (SOP) for the 'Management and Identification of Medical Outliers in Non-Medical Wards'. The SOP clearly identified actions staff should take in the event of outlying patients and recorded contact details for all medical and wards used for outlying patients. (*Outliers* were patients recorded as being under a medical specialty but receiving care and treatment on a surgical ward). The SOP clarified that in order to minimise the number of medical teams with outliers on 7 North the only teams looking after these outliers should be the gastroenterology, endocrinology and infectious diseases team. Otherwise Ealing Hospital ran a ward-based care system. The usual practice was that the patients on any given ward would be cared for by the team based on that ward.

At the time of inspection, the endoscopy service at Ealing Hospital was applying for Joint Advisory Group (JAG) accreditation.

Staff protected the rights of patients subject to the Mental Health Act and followed the Code of Practice. At handover meetings, staff routinely referred to the psychological and emotional needs of patients, their relatives and carers. Patients with mental health needs were discussed at the daily safety huddle. Care plans and risk assessments, together with any actions needed to mitigate risks were identified at the huddles.

Nutrition and hydration

Staff gave patients enough food and drink to meet their needs and improve their health. They used special feeding and hydration techniques when necessary. The service made adjustments for patients' religious, cultural and other needs.

At the time of inspection due to the trust's COVID-19 visiting policy, patients requiring support with eating and drinking were allowed one visitor a day, as long as the visitor was supporting the patient with feeding.

Staff made sure patients had enough to eat and drink, including those with specialist nutrition and hydration needs. The trust offered a finger food menu, namely was food which could be eaten easily with hands. The trust also offered menus for patients unable to place their own menu order. Staff could tick the options on a menu for the patients.

Patients had access to a range of menus that met their religious and cultural needs. For example, a kosher menu, vegan menu, allergy aware menu, and modified texture menu for people with difficulty swallowing. The trust could also provide translated menus in other languages, braille and large print.

Staff fully and accurately completed patients' fluid and nutrition charts where needed. Staff used a nationally recognised screening tool to monitor patients at risk of malnutrition. All the nutritional assessments and fluid balance

charts we viewed were complete and up to date. Where a dietitian had been involved in a patient's care, this was documented. We viewed the outcome of a malnutrition universal screening tool (MUST) audit for the month of January 2022. This recorded 95.3% of MUST records were completed correctly, which was within the trust's audit standard of between 90% and 100%. This was an improvement from the last inspection.

We reviewed the outcome of a monthly fluid balance management audit dated January 2022. This found compliance with completion of fluid balance charts was 83.75% for the integrated medicines division. This was due to two wards not meeting the trust's 96% to 100% standard. These were ward 6 North, that scored 84%; and ward 6 South, that scored 60%.

Staff said patients were offered seven hot drinks a day and regular water rounds. Patients were offered three snacks a day, as well as breakfast, lunch and dinner. The trust used a 'red tray' system to identify patients requiring support with eating. However, patients we spoke with gave mixed comments on the quality of the hospital's food.

Specialist support from staff such as dietitians and speech and language therapists were available for patients who needed it. The 'national audit of dementia care in general hospitals 2021' found 89.6% of Ealing Hospital patients living with dementia received an assessment of nutritional status performed by a healthcare professional. This was slightly worse than the national average of 92.5%. However, 97.7% of these assessments included a body mass index (BMI) assessment or weight assessment; this was better than the national average of 85.1%.

The medicines division had submitted a business case to the trust board for three new roles of nutritional assistants; this was to support staff on the wards with patients requiring support with eating and drinking.

Pain relief

Staff assessed and monitored patients regularly to see if they were in pain and gave pain relief in a timely way. They supported those unable to communicate using suitable assessment tools and gave additional pain relief to ease pain.

Ealing Hospital had a pain team. Staff told us support from the pain management team was available to patients on referral from medical clinicians. A named consultant anaesthetist was the trust lead for pain management. The acute pain nursing team consisted of 2.93 whole time equivalent (WTE) band 7 and six 3.35 band 6 WTE Monday to Friday. There was a fixed rotation on each site for continuity of care, but staff worked flexibly to cover other sites if required.

Staff assessed patients' pain using a recognised tool and gave pain relief in line with individual needs and best practice. Staff on the Older Persons Short-Stay Unit (OPPSSU) were using the SSKIN bundle to record pain, (skin, surface, keep moving, incontinence, nutrition). The bundle did not use a pain scale to assess pain. A pain scale could have assisted doctors in creating a treatment plan and measuring the effectiveness of treatment.

We viewed results from the integrated medicines division's monthly quality audit programme April to September 2021. This found the lowest rate of patients who felt their pain had been managed appropriately was 95% in April 2021, the highest rates were 100% in May, June, August and September 2021.

Patients we spoke with told us they received pain relief soon after requesting it.

Staff prescribed, administered and recorded pain relief accurately. However, we saw one prescription chart on the Older Persons Short-Stay Unit (OPPSSU), where a patient was prescribed a local anaesthetic patch. The patient's prescription read, "once daily to knees." However, the staff on the ward had interpreted this as one patch to one knee. The prescription was unclear as to whether patches should have been applied to one or both knees.

Patient outcomes

Staff monitored the effectiveness of care and treatment. They used the findings to make improvements and achieved good outcomes for patients.

The service participated in relevant national clinical audits. The COVID-19 pandemic delayed the piloting and rolling out of some national audit data collection.

Ealing hospital participated in the 'National audit of dementia care in general hospitals 2021'. The audit found 42% of patients with dementia received care and treatment on care of the elderly wards and 36% received their care and treatment on "other medical" wards.

Overall, outcomes for patients were positive, consistent and met expectations, such as national standards. The trust had introduced a new electronic application to monitor patient outcomes. At the time of inspection, the trust informed CQC that their quality dashboards were being updated to reflect the new audit programme which consisted of six-monthly nursing audits. Results from the audits were produced on an application (app) to enable staff in accessing audit results from a variety of media.

We viewed results from the nursing profile audits on the app. This recorded that all wards across the integrated medicines division were meeting the 90% minimum standard for: cannulas (peripheral and central); falls; hand hygiene; national early warning score (NEWS2); nutrition and hydration; Waterlow audits or pressure ulcers. There was one exception in the period October 2021 to December 2022, this was ward 8 South which had not met the 90% standard for NEWS2 (75%) and nutrition and hydration (80%). Overall, the division had and average nursing profile audit score that was better than the trust's 90% standard. For example, 5 North had an average score in the period of 98.6%.

We viewed London wide comparative data on cancer patients seen by a cancer specialist within two weeks of an urgent GP referral. In the previous quarter from January 2022 the trust's performance was in the middle of all NHS trust's in London. The trust had seen 88.4% of cancer patients within two weeks of an urgent GP referral in the period. This was lower than the published recommendations of 93%.

Managers and staff carried out a comprehensive programme of repeated audits to check improvements over time. We viewed the trust's integrated medicines division dashboard for January 2022. This indicated that in January 2022 wards in the division were not meeting the trust's target of less than one patient fall per month, with nine patient falls being recorded in the month. The dashboard also indicated that the division were not meeting the trust's target of less than one hospital acquired pressure ulcers grade 2 per month, with two grade two pressure ulcers having been recorded, (one hospital acquired pressure ulcer was recorded on ward 4 South and another hospital acquired pressure ulcer was recorded on 6 North). The dashboard also indicated that the trust's target of less than one hospital acquired pressure ulcer grade 3 to 4 had not been met, (one hospital acquired pressure ulcer being recorded on ward 4 South).

The 'Myocardial Ischaemia (MINAP)' heart attack audit for 2021 found patients having echocardiogram after STEMI was 88% at Ealing Hospital. This was higher than the 76% national average. (ST-Elevation Myocardial Infarction (STEMI) is a type of heart attack during which one of the heart's major arteries is blocked).

The MINAP audit found patients with suspected STEMI door-to-balloon (D2B) time, (this is the interval between patient arrival at the hospital to balloon angioplasty of the occluded coronary artery), within 60 minutes was lower than the 74% national average at 50%.

The trust was not a designated London heart attack centre and therefore saw very few STEMI patients appropriate for primary percutaneous coronary intervention (PCI). Percentages were lower than the national average because the trust saw fewer than 20 patients in the reporting period.

The MINAP audit found cases reported for referral to cardiac rehabilitation was much lower than the 81% national average, with the Ealing Hospital rate being 11%. Following the inspection, the trust told us they had been allocated funding for a new cardiac rehab service that will aim to address the deficiencies in the current service and will provide for inpatient phase 1 cardiac rehab ensuring onward referral to appropriate services.

The MINAP audit found the number of patient at Ealing Hospital receiving an echocardiogram, (echo is a system that uses sound waves to produce images of the heart), was lower than the national target of 90%, with 76% of patients receiving an echo on admission. Following the inspection, the trust told us that they had an action plan to ensure that an echo is done pre discharge as per guidance.

Managers used information from the audits to improve care and treatment. Results of the 'Heart Failure National Audit 2019-2020' found a mixed picture from the key areas of the 2018-2019 audit. In response to the audit the trust had an improvement action plan in place to address areas identified as requiring improvement. The action plan had a clear process of monitoring and review.

Managers and staff investigated outliers and implemented local changes to improve care and monitored the improvement over time. We viewed data dating from 1 November 2021 to 31 January 2022 on the numbers of medical patient outliers per week that were receiving care and treatment on surgical wards and not on integrated medicine division wards. The lowest rate was in the week commencing 1 November 2021 with 15 medical care patient on surgical wards. The highest rate was 96 patients on surgical wards in the week commencing 3 January 2022. The average rate of outlying patients in the period was 46 patients a week.

Outliers were reviewed daily to review progress, care and treatment plans, review discharge and ensure consultants were aware of patients being moved. Outlying patients were placed in to surgical rather than escalation wards. There were extra junior doctors on duty to oversee outliers, and extra agency or bank nursing staff would be requested to assist staff on the wards. The usual practice at Ealing Hospital was that outlying patients would be cared for by the team based on the ward.

Competent staff

The service made sure staff were competent for their roles. Managers appraised staff's work performance and held supervision meetings with them to provide support and development.

Staff were experienced, qualified and had the right skills and knowledge to meet the needs of patients. Cancer teams were co-located. All staff working in cancer care received regular competency assessments, including band 4 cancer support workers.

Managers gave all new staff a full induction tailored to their role before they started work. Staff we spoke with told us the trust's initial induction programme was comprehensive and it prepared them for their roles.

Medical care (including older people's care)

All ward managers had an agency/bank staff local induction folder. Any new agency or bank staff working on the ward completed a check list at the beginning of their first shift. We viewed the bank and agency staff induction and found this included: orientation to the ward; telephone numbers for emergencies including bleeps; policies, including medical gases; records and documentation; incident reporting; and handover and safety huddle meetings.

Managers supported staff to develop through yearly, constructive appraisals of their work. We viewed the integrated medicines division's key performance indicator (KPI) dashboard dated January 2022. This recorded that 92.83% of staff had received an annual appraisal, this was better than the trust's 80% KPI standard. This was a significant improvement since the last inspection where completion of appraisals was 62%.

Managers supported nursing staff to develop through regular, constructive clinical supervision of their work. Nursing and healthcare assistants, we spoke with told us they received regular supervision.

Managers supported medical staff to develop through regular, constructive clinical supervision of their work. The service had a configuration of job plans to appeal to medical staff working in older people's services but could also offer medical staff experiences in different disciplines. The service was also looking at some medical staff working a 'half and half' job role across two specialisms.

The integrated medicines division had 19 consultants delivering care on the wards at Ealing Hospital; 17 of these had up to date job plans, (these are agreements that sets out a consultant's duties, responsibilities and objectives). Two consultants' job plans had passed their expiry date, a consultant in cardiology and locum consultant in respiratory medicine. The trust informed us the expired job plans were being addressed as a priority.

The clinical educators supported the learning and development needs of staff. The practice development nurses (PDN) provided daily 'Stop Look Listen and Learn' sessions. This was a video conference teaching platform for nurses and health care assistants (HCA). The sessions enabled staff to access training flexibly and develop skills and knowledge in a structured and consistent approach, as well as opportunities to share best practice. The sessions provided PDN with the opportunity to continuously evaluate staff learning needs so that relevant and appropriate teaching materials could be created to focus on different topics every week.

The PDN had completed focused ward-based group training. This included all clinical staff receiving training in the National Early Warning Score (NEWS2) and sepsis. Emergency care training was covered in acute life-threatening events recognition and treatment (ALERT) training and in the bedside emergency assessment course for healthcare staff (BEACH) training, this training was in addition to mandatory training. The integrated medicines division had also completed daily NEWS2 teaching using revised teaching materials created by the trust's critical care outreach team. All staff had access to a certificated NEWS2 e-learning course, including healthcare assistants (HCA).

Managers made sure staff attended team meetings or had access to full notes when they could not attend. Staff told us they were emailed minutes of team meetings.

Staff had the opportunity to discuss training needs with their line manager and were supported to develop their skills and knowledge. Managers made sure staff received any specialist training for their role. For example, Macmillan nurses trained the trust's cancer clinical nurse specialists (CNS).

Managers identified poor staff performance promptly and supported staff to improve. We viewed three serious incident root cause analysis (RCA) investigation reports. The reports clearly identified which managers were responsible for staff learning as a result of incidents, as well as the lessons to be learnt from serious incidents.

Medical care (including older people's care)

Multidisciplinary working

Doctors, nurses and other healthcare professionals worked together as a team to benefit patients. They supported each other to provide good care.

Staff held regular and effective multidisciplinary meetings (MDT) to discuss patients and improve their care. We attended an MDT on ward 6 North, endocrine and gastroenterology. The meeting involved a group of endocrine and gastroenterology professionals making decisions regarding the recommended treatment of individual patients.

Staff worked across health care disciplines and with other agencies when required to care for patients. The integrated medicines division worked closely with the division of emergency and ambulatory care to provide acute assessment and same day emergency care.

When patients received care from a range of different professionals, this was coordinated. Multidisciplinary teams were involved in assessing, planning and delivering patients care and treatment. Staff collaborated to understand the range and complexity of patients' needs. For example, cancer services had worked with MacMillan and received an occupational therapist OT as a result of this.

The hospital had a range of allied health professionals that supported medical and nursing staff. Staff told us nurses and doctors worked well together within the medicine's division. There were daily multidisciplinary board rounds which included, nurses, doctors, OT and physiotherapists.

All medical wards had an allocated physiotherapist and an occupational therapist on weekdays. Physiotherapy weekend cover was provided by an on call rota whereby the clinician would be on site to treat and see all patients with chest complications and any who are at risk of deterioration from a respiratory perspective. There was a voluntary weekend rota for a second physiotherapist to provide rehabilitation to patients. The voluntary rota for occupational therapy was less popular partly due to the continued challenge OT faced as a result of vacancies. Of the 53 weekends from 20 February 2021 and 28 February 2022, OT cover was provided on 27 Sundays and 14 Saturdays. On 8 weekends there was OT cover on both Saturday and Sunday. There were 33 weekends where either Saturday or a Sunday OT cover was provided. There were 20 weekends where there was no OT cover provided.

Dietetics was a mainly adult inpatient service with a workforce that included both qualified dietitians and dietetic assistants.

The trust had a podiatry team that worked flexibly across the trust, but primarily at Ealing and Northwick Park Hospitals.

Individual speech and language therapists (SLT) were not allocated to specific wards/ medical teams. SLT covered all areas. Work allocation was dependent on referrals for SLT services.

Staff referred patients for mental health assessments when they showed signs of mental ill health, or depression.

Patients had their care pathway reviewed by relevant consultants. We viewed the trust's 'organogram', which was an organizational chart that detailed the speciality pathways for patients attending the hospital. A consultant reviewed care and treatment based on the patient's care speciality.

Staff worked closely with a central London NHS trust for cancer patients. Patients receiving care on the Ealing Hospital cancer pathway for chemotherapy and radiation therapy were aligned to another NHS trust in central London.

Medical care (including older people's care)

The trust was a joint tertiary centre for head and neck cancer, with another London NHS trust. The oncologists sat with the other NHS trust, but were part London North West University Healthcare Trust's multidisciplinary team. Staff told us working with other trusts on cancer pathways was effective.

Staff working in cancer care told us accountability needed to be clarified in cancer multidisciplinary working. The manager said ward teams needed to be clear on whether they were requesting an opinion from the cancer team or whether a patient was being referred to the cancer team.

Seven-day services

Key services were available seven days a week to support timely patient care.

Consultants led daily ward rounds on all wards, including weekends. Patients were reviewed by consultants depending on their care pathway, seven days a week.

The inpatient wards at Ealing Hospital were always open and medical staff were always available to provide patient care and advice. Staff could call for support from doctors and other disciplines, including mental health services and diagnostic tests, 24 hours a day, seven days a week.

Health promotion

Staff gave patients practical support and advice to lead healthier lives.

The service had relevant information promoting healthy lifestyles and support on wards/units. Information on the COVID-19 vaccine was available on the trust's website.

Staff assessed each patient's health when admitted and provided support for any individual needs to live a healthier lifestyle. Staff gave patients information on smoking cessation, exercise and diet.

Consent, Mental Capacity Act and Deprivation of Liberty Safeguards

Staff supported patients to make informed decisions about their care and treatment. They followed national guidance to gain patients' consent. They knew how to support patients who lacked capacity to make their own decisions or were experiencing mental ill health. They used measures that limit patients' liberty appropriately.

Staff were trained in dementia awareness. The dementia training standards framework was commissioned by Department of Health (DOH) together with Health Education England (HEE) and aims to support the development and delivery of dementia education for the healthcare workforce. LNWH dementia awareness training had recently been redesigned to become compliant with the guidelines so that all staff were confident in the provision of person-centred care to patients with dementia/delirium needs.

Mental Capacity Act 2005 (MCA) and Deprivation of Liberty Safeguards (DoLS), (DoLS is part of the MCA and is a legal framework for individuals who lack the capacity to consent to be accommodated in a hospital or care home in order to receive care and treatment). MCA and DoLS training were incorporated into the trust's safeguarding adults' level 1, level 2 and level 3 training modules.

Medical care (including older people's care)

At our last inspection we found that staff understanding of MCA and DoLS assessments was variable. At this inspection we found that staff understood how and when to assess whether a patient had the capacity to make decisions about their care. Staff we spoke with had understanding of capacity and consent issues and were able to describe the correct process for establishing capacity and obtaining consent. Staff knew where they would get further advice if needed. Staff told us there had been a drive at the trust on developing staff understanding of the Mental Capacity Act 2005.

Staff clearly recorded consent in the patients' records. Staff gained consent from patients for their care and treatment in line with legislation and guidance. We found in the records we viewed that consent to care and treatment was obtained in accordance with legislation and guidance, including the Mental Capacity Act 2005. Patients were supported to make decisions and, where appropriate, their mental capacity was assessed and recorded. This was an improvement from the last inspection where we found capacity assessments and consent had not been consistently recorded.

Staff made sure patients consented to treatment based on all the information available. When patients could not give consent, staff made decisions in their best interest, taking into account patients' wishes, culture and traditions. Patients aged 16 and over who lacked the capacity to make a decision, a decision was made by applying the 'Best Interest' principle, as set out in the Mental Capacity Act 2005.

Nursing and clinical staff received and kept up to date with training in the Mental Capacity Act and Deprivation of Liberty Safeguards. Staff told us the Mental Capacity Act 2005 and DoLS training was mandatory for all staff. Deprivation of liberty only occurred when it was in a person's best interests and was a proportionate response to the risk and seriousness of harm to the person, giving due consideration to the least restrictive option that could be used to ensure the person got the necessary care and treatment. Senior nursing staff and doctors we spoke with could describe the processes they would follow to initiate 'deprivation of liberty safeguards' (DoLS).

Staff could describe and knew how to access policy and get accurate advice on Mental Capacity Act and Deprivation of Liberty Safeguards. The trust's safeguarding team had a road map for the implementation of the Mental Capacity (Amendment) Act (MCA) 2019 and the introduction of the Liberty Protection Safeguards (LPS) which will replace the Deprivation of Liberty Safeguards (DoLS). As a result of the amendments to the Mental Capacity Act NHS trusts will be expected to authorise and oversee deprivation of liberties instead of local authorities. The safeguarding team had published information on LPS in the staff PULSE newsletter and were attending ward managers and matrons' meetings to inform staff of the changes.

Managers monitored how well the service followed the Mental Capacity Act and made changes to practice when necessary. For example, the integrated medicines division had audited the use of mittens. (Mitten restraints are used to prevent the dislodgment of tubes, lines and catheters). The audit outcome found in 80% of cases across Ealing and Northwick Park Hospitals 80% of patients had DOLS was applied following the mittens being used and none applied the least restrictive principle. In response, the trust had introduced one to one care as being the least restrictive alternative to the use of mittens and staff also used a 'bay watch' to monitor patients at risk of removing tubing. The use of bay watch requires a member of the MDT to be present in the bay at all times in order to monitor patients.

Is the service caring?

Good ↑

Our rating of caring improved. We rated it as good.

Medical care (including older people's care)

Compassionate care

Staff treated patients with compassion and kindness, respected their privacy and dignity, and took account of their individual needs.

Staff were discreet and responsive when caring for patients. Staff took time to interact with patients and those close to them in a respectful and considerate way. We saw staff demonstrating compassionate and caring attitudes and building positive relationships with patients.

At our last inspection we observed patients being cared for in corridors on trolley which impacted on patients' privacy and dignity. At this inspection we saw patients were being care for in bed bays only and saw that patients' privacy and dignity was respected and maintained by staff.

Although patients said staff treated them well and with kindness, most patients we spoke with raised issues with the hospital's COVID-19 visiting policy. The policy was that one visitor was allowed on the ward at a time by appointment only. Visiting was only allowed for patients requiring feeding assistance or palliative care. Some patients told us the lack of visitors had an impact on their experience of care.

Staff understood and respected the individual needs of each patient and showed understanding and a non-judgmental attitude when caring for or discussing patients with mental health needs.

Staff understood and respected the personal, cultural, social and religious needs of patients and how they may relate to care needs. The trust had recently appointed a new head of patient experience. Chaplaincy and bereavement services were part of the patient experience team. The team monitored patient experience, including the outcomes of the Friends and Family Test (FFT) and national patient surveys. The Friends and Family Test (FFT) is an important feedback tool that supports the fundamental principle that people who use NHS services should have the opportunity to provide feedback on their experience. Listening to the views of patients and staff helps identify what is working well, what can be improved and how.

Staff told us patient feedback had identified food as an area of concern from patient feedback. In response the patient experience team had liaised with the catering manager and new menus had been implemented. The dietitians were also working with wards to ensure patients were aware of the multiple social and religious menu choices the catering team offered.

Emotional support

Staff provided emotional support to patients, families and carers to minimise their distress. They understood patients' personal, cultural and religious needs.

Staff gave patients and those close to them help, emotional support and advice when they needed it. Cancer services had a policy that the telephone was always answered to provide emotional support and advice to patients and families. If the phone was answered by a band 4 cancer support worker, they would take a message and pass it on to the patient's clinical nurse specialist. Staff told us cancer services placed importance on patients having access to immediate support when contacting the service.

Staff supported patients who became distressed in an open environment and helped them maintain their privacy and dignity.

Staff undertook training on breaking bad news and demonstrated empathy when having difficult conversations.

Medical care (including older people's care)

Staff understood the emotional and social impact that a person's care, treatment or condition had on their wellbeing and on those close to them.

Understanding and involvement of patients and those close to them

Staff supported patients, families and carers to understand their condition and make decisions about their care and treatment.

Staff made sure patients and those close to them understood their care and treatment. The trust had recently recruited a head of patient experience. The head of patient experience told us their role was to understand what mattered to patients and families.

Patients and their families could give feedback on the service and their treatment and staff supported them to do this. We viewed the key performance indicator dashboard for January 2022. This found the response rate for the Friends and Family Test (FFT) was 100%. In the integrated medicines division 98.6% of patients responded that they would recommend the integrated care division to their friends and family in the FFT and none said they would not recommend the service.

Staff supported patients to make advanced decisions about their care. We reviewed three 'do not attempt cardiopulmonary resuscitation' (DNACPR) forms that had been completed within the Resuscitation Council UK guidelines. We found clear records, where possible, of the discussions between staff and patients and, where appropriate, their families. DNACPR forms completed in the community or during previous admissions or in the community were reviewed by a consultant. Staff told us DNACPR decisions would be cancelled where it was felt they no longer applied.

Staff supported patients to make informed decisions about their care. For example, cancer services had introduced a patient led follow up in breast, colorectal and urology. Staff told us cancer services were trying to move away from an over medicalised model of care and treatment.

Patients gave positive feedback about the service. Patients were positive about the care and treatment they received. However, most patients we spoke with told us the trust's policy on restricted visiting due to COVID-19 had an impact on their sense of wellbeing. A patient told us, "I've been here for nearly a week and I haven't been allowed a visitor." Staff told us the wards were equipped with tablet computers and all patients could book a video call. Families could telephone the wards and speak with patients at any time.

Is the service responsive?

Requires Improvement 

Our rating of responsive stayed the same. We rated it as requires improvement.

Service planning and delivery to meet the needs of the local people

The service planned and provided care in a way that met the needs of local people and the communities served. It also worked with others in the wider system and local organisations to plan care.

Medical care (including older people's care)

Managers planned and organised services so they met the changing needs of the local population. The number of admissions for the three specialties most admitted to in the division of integrated medicine at Ealing Hospital between 1 November 2021 and 31 January 2022 were: general internal medicine (GIM), with 1039 admissions in the period or 83% of total admissions; cardiology with 120 admissions, or 10% of admissions in the period; and geriatric medicine with 30 admissions, or 2% of total admissions in the period.

Gastroenterology was not part of the integrated medicines division, as it was a specialty in the St Mark's division. In the period 1 November to 31 January 2022 there had been 581 admissions in gastroenterology.

The number of Ealing residents living with dementia was estimated to be 2,630. This equated to 6.8% of the total population aged 65 and over. Due to the ageing population of Ealing, this number was projected to rise significantly in the next 25 years, estimated to be 8.4% of the total population over the age of 65. In response, the trust had developed a strategy for dementia care. The dementia strategy 2021-2024 was aligned to and built on the national dementia care strategy 2013. The trust's dementia care strategy provided a blueprint for the development of dementia services at the trust. The strategy included: diagnosing well; living well; supporting well; and dying well. Delivery of the plan was overseen by the trust's matron for dementia and the progress of the strategy was monitored at the quarterly meetings of the trust's dementia strategy steering group.

Cancer services were trustwide. Staff told us cancer services were "very integrated" in North West London. The trust had cancer clinical nurse specialists (CNS) for all the main tumour sites. Staff worked in their specialist teams. These teams sat within a larger cancer team that worked across the entire cancer pathway.

All patients on the acute medical unit (AMU) at Ealing Hospital had a physical review by a consultant each weekday morning. Patients who transferred to AMU from the Emergency Department (ED) between 9am and 4pm, Monday to Friday, were physically reviewed by a consultant. All patients were reviewed at 4pm at a consultant led board round, Monday to Friday. Patients on the AMU were not reviewed by a consultant on Saturday or Sunday. However, an on-call consultant was available for advice 24 hours a day. Patients admitted over the weekend received a consultant review at the post take ward round.

Staff knew about and understood the standards for mixed sex accommodation and knew when to report a potential breach. The trust informed us there had been no mixed sex breaches in the 12 months prior to the inspection.

The integrated medicines division were involved in a trust quality improvement audit which was assessing delays in the inpatient magnetic resonance imaging (MRI) scans process and whether this increased inpatients' length of stay. The audit report was in the process of being finalised at the time of inspection.

In order to minimise the number of medical teams with outliers residing on 7 North. The general internal medicine (GIM) specialties had decided that the only teams looking after these outliers should be the gastroenterology, endocrinology and infectious diseases teams.

Facilities and premises were appropriate for the services being delivered. At the time of inspection, on 9 February 2022, of the 247 general and acute beds open, 226 were occupied. On 10 February 2022, of the 241 general and acute beds open, 229 were occupied.

Medical care (including older people's care)

The integrated medicine division provided a total of 163 inpatient beds. These wards were: 4 South (cardiology) which provided 32 beds; 5 North (older persons short-stay unit) provided 23 beds; 6 North (diabetes and endocrinology) provided 34 beds; 6 South (COVID-19) provided 31 beds; 8 South (infectious diseases) provided 23 beds; 10 North (clean respiratory) provided 20 beds.

The division of integrated medicine did not include the acute medical unit (AMU) or 5 South ward, as this sat in the division of emergency medicine. The AMU provided 30 acute beds.

Gastroenterology, 7 South, sat with St Mark's Hospital. St Mark's is managed by London North West University Healthcare NHS Trust, it is the only hospital in the world to specialise entirely in intestinal and colorectal medicine and is a national and international referral centre for intestinal and colorectal disorders. 7 South ward provided 34 beds.

The local clinical commissioning group (CCG), as a commissioner, held the service level agreement (SLA) between Ealing Hospital and a local mental health trust, rather than the London North West University NHS Trust. The trust had a Memorandum of Understanding which outlined the working agreements between the trust and the local mental health trust. We viewed Terms of Reference for the mental health steering group, which facilitated the joint organisational approach to physical health and mental health provision.

Staff could access emergency mental health support 24 hours a day 7 days a week for patients with mental health problems, learning disabilities and dementia. However, staff told us managing patients with mental health needs was becoming increasingly challenging, due to an increase in the number of patients presenting with mental health needs. Staff told us they were increasingly expected to manage patients in mental health crisis. Staff said this was further complicated by a lack of availability of registered mental health nurses (RMN) to provide one to one care for patients with mental health needs. Staff said a shortage of mental health beds meant patients experiencing acute mental health crisis were often on the wards for prolonged periods, even when they were fit for discharge to mental health services.

The service had systems to help care for patients in need of additional support or specialist intervention. For example, we saw two sets of notes which contained confusion care pathways, which are tools for supporting the care and treatment of patients with dementia or delirium, and we saw that these were followed and reviewed regularly.

Meeting people's individual needs

The service was inclusive and took account of patients' individual needs and preferences. Staff made reasonable adjustments to help patients access services. They coordinated care with other services and providers.

Staff made sure patients living with mental health problems, learning disabilities and dementia, received the necessary care to meet all their needs. The trust had a dementia matron and a band 7 clinical nurse specialist based at Ealing Hospital to support the wards with care planning for complex patients. The trust had dementia champions, these were staff members (clinical or non-clinical) who had a keen interest in dementia care and could ensure seamless delivery and development of dementia care.

Wards were designed to meet the needs of patients living with dementia. The confusion icon was a symbol which provided a way of identifying patients who required extra support. The symbol was placed as an electronic tag on the patients record system and hung magnetically above the patient's bed to ensure that those living with dementia, delirium and/or memory impairment could be easily identifiable by staff so that their care was planned appropriately. However we found an example where this was not actioned.

Medical care (including older people's care)

Staff supported patients living with dementia and learning disabilities. On admission patients who presented with memory loss or confusion were put on the confusion care pathway. This was an initiative designed to help identify and support patients who had additional needs encompassing their memory.

The service offered pictorial menus and menus with larger print, as well as coloured crockery, modified cutlery and coloured trays to discreetly identify people in need of additional support with eating and drinking.

The trust had a learning disability and autism pathway for patients.

Staff understood and applied the policy on meeting the information and communication needs of patients with a disability or sensory loss. The trust's 'Hospital passports' scheme for patients living with a learning disability and autism, allowed patients to identify to staff their preferences and dislikes in a pictorial format. There was also an 'Easy Read' menu available for patients. The trust had a learning disability nurse specialist to support patients with their care and treatment.

The service had information leaflets available in languages spoken by the patients and local community. The trust had access to software that could provide translation of written materials including British Sign Language upon request. For example, leaflets and trust letters.

Managers made sure staff, and patients, loved ones and carers could get help from interpreters or signers when needed. Staff told us interpreters were available both in person and via the telephone. We saw a form staff could use to request face to face interpreters, for patients where English was not their first language. The form had instructions for staff on booking interpreters prior to appointments to ensure they were available to support patients during an appointment. Staff could also book telephone interpreters. However, we found some ward clerks were not clear about the procedure for accessing interpreters via the phone.

Staff had access to communication aids to help patients become partners in their care and treatment. Patients that used sign language, could book an interpreter with the trust in advance of their appointment. Ealing hospital was equipped with a hearing loop, this is a special type of sound system for use by people with hearing aids, this greatly reduced background noise, competing sounds, reverberation and other acoustic distortions that reduced the clarity of sound.

The medicines division operated a 'baywatch' scheme. This involved a member of staff remaining on a bay in a ward where there were one or more patients who needed to be supervised due to dementia or challenging behaviour. We saw an HCA acting in this role on the acute medical unit (AMU). However, due to the patient mobilising around the ward the HCA had to leave the bay unsupervised, to supervise another patient who had left the bay.

Access and flow

The trust was not meeting the referral to treatment national standard but had a recovery plan in place and was working jointly with the ICS to focus on achieving pre-COVID-19 activity levels.

Patients were admitted under a lead speciality. If that team required another team's input due to it being identified that the patient had a condition which should be managed by another team, this would be facilitated by a ward based transfer to the correct admissions unit, and not via the emergency department (ED). We viewed the trust's 'organogram', which was an organizational chart that detailed the speciality pathways for patients attending the hospital.

There were weekly integrated medicines divisional inpatient performance and flow meetings. These meetings monitored and were accountable for flow and the operational performance of in-patient wards within the integrated

medicines division. The meeting was attended by general managers, matrons from both Ealing and Northwick Park Hospitals, the divisional information analyst and a patient flow facilitator. The group reviewed KPI by site, reported on local improvement initiatives and any shared learning within the division. At the time of inspection, on 9 February 2022, of the 247 general and acute beds open, 226 were occupied. On 10 February 2022, of the 241 general and acute beds open, 229 were occupied.

In January 2022 the trust was in the highest 25% of all trusts nationally at 100% for the proportion of cancer patients treated within 31 days of a decision to treat. However, the trust was not meeting the national 85% target for patients treated within 62 days of an urgent GP referral at 78.24%.

We reviewed trust wide data for referral to treatment times (RTT). In March 2022 there were 56200 patients on the waiting list, this was an increase from February 2022 when there 55500 patients on the waiting list. There were 465 patients that had waited over 52 weeks in March 2022, but this was a reduction on the previous month when the figure was 562 patients. The overall trend in consultant led referral to treatment times from January 2021 to January 2022 was downwards. This meant the trust were addressing the backlog of patient waiting for care and treatment as a result of the COVID-19 pandemic.

We saw trustwide data for January 2022 which showed that 84.7% of patients were seen within 18 weeks in “other medicine”, and 14.6% of “other medicine” patients were seen within 18 to 26 weeks.

Managers and staff worked to make sure patients did not stay longer than they needed to. The ‘national audit of dementia care in general hospitals 2021’ found at Ealing Hospital 60% of patients living with dementia reviewed in the audit, which was the equivalent of 30 patients, had a hospital stay of two to 10 days. This was higher than the national average in the audit of 47.7%. The audit also found 22% of patients, the equivalent of 11 patients, had a hospital stay of between 11 and 20 days. This was lower than the national average in the audit of 25.8%.

Staff did not move patients between wards at night. Managers monitored that patient moves between wards/services were kept to a minimum. Exceptional moves at night were discussed at morning safety huddles. The trust was no longer using the 'Plus One' escalation policy which we saw at our last inspection where at times of high activity, patients were cared for in the corridor of the ward and impacted on patient's privacy and dignity.

Managers and staff worked to make sure that they started discharge planning as early as possible. Staff planned patients’ discharge carefully, particularly for those with complex mental health and social care needs. The trust defined in-hours discharges as discharges between 7am and 8pm. Out of hours discharges were defined as discharges between 8pm and 7am. Out of hours discharges were recorded on the electronic patient record system. The trust informed us that there could be an element of error with out of hours discharges, due to the system not being updated until the ward clerk was on shift. Ward clerks worked from 9am to 5pm and did not work at weekends.

Between January and December 2021 there had been 8924 patients discharged between 7am and 8pm. There had been: 427 patients discharged between 8pm and 10pm; 172 patients discharged between 10pm and midnight; 227 patients discharged between midnight and 7am. This was a total of 826 out of hours discharges, or 9.3% of discharges taking place out of hours.

We viewed trustwide data on delayed discharges. This indicated from February 2021 delayed discharges were decreasing month on month. For example, the rate in February 2021 was 46.3%. The rate in October 2021 was 40.2%. However, in November 2021 there was a large increase in the rate of delayed discharges at 62.8%. This trend continued in subsequent months with the highest rate being 64.9% in January 2022.

Medical care (including older people's care)

In February 2022 the main reason identified for delayed discharges of 14 days and over, was awaiting available residential or nursing care home bed. At 34.2% this was higher than the integrated care system (ICS) average of 21% in the same period.

We saw a patient on the acute medical unit (AMU), that had their discharge delayed. The patient was subject to a section order under the mental health act. The patient was fit for discharge to a mental health provider. However, staff told us they could not discharge the patient, due to a lack of availability of mental health beds. Staff told us they were frequently required to provide care for patients with mental health needs due to the lack of available mental health beds.

At our last inspection, we found that patients who had been identified as living with dementia did not have a care pathway document recorded or had one partially completed. At this inspection, records we reviewed showed that care pathways were documented in full for patients living with dementia.

The 'national audit of dementia care in general hospitals 2021' found 100% of Ealing Hospital patients living with dementia received a single plan/summary for discharge with clear updated information. This was better than the national 85.8% average. The audit also found 100% of patients had discharge planning initiated within 24 hours of admission. This was much better than the national average of 51.3%.

Managers monitored the number of delayed discharges, knew which wards had the highest number and took action to prevent them. The integrated medicines division had weekly qualitative and quantitative reviews of unplanned and planned discharges and compared this with patients estimated dates of discharge on the electronic patients record system. Following the weekend, general managers undertook a review with the weekend duty doctor and charge nurse of each ward. Reasons for unsuccessful planned discharges were discussed and documented. Plans for new discharges were also discussed and documented. This information was reviewed weekly at the divisional flow meeting.

Staff supported patients when they were referred or transferred between services. Managers monitored patient transfers and followed national standards. The 'national audit of dementia care in general hospitals 2021' found 58% of Ealing Hospital patients living with dementia were admitted from their own homes and 51.1% of patients were discharged to their own homes. The audit found 20% of patients were admitted from residential care homes, which was slightly higher than the national average of 17.9%; and 15.5% were discharged to residential care homes. This was lower than the 19.8% national average. The audit also found 22% of patients living with dementia were admitted from nursing homes, which was lower than the national average of 22.1%. 26.7% of patients living with dementia were discharged to nursing homes, which was slightly higher than the national average of 25.8%.

Learning from complaints and concerns

It was easy for people to give feedback and raise concerns about care received. The service treated concerns and complaints seriously, investigated them and shared lessons learned with all staff. The service included patients in the investigation of their complaint.

Patients, relatives and carers knew how to complain or raise concerns. All the patients we spoke with said that they had not raised any complaints with the hospital, as they had not had any. Patients said they thought staff were approachable if they did wish to raise issues.

Information regarding complaints was available on all the wards. Staff told us information in other languages could be requested from the trust's accessible communications team.

Medical care (including older people's care)

The service clearly displayed information about how to raise a concern in patient areas. Information on the patient liaison service (PALS) was displayed on noticeboards in the hospital and available on the trust's website.

Staff understood the policy on complaints and knew how to handle them. Complaints were managed in accordance with the trust's policy and lessons were learnt. Staff and managers told us they preferred to resolve minor complaints at ward level. Staff told us these were not recorded, but if they could not deal with the complaint immediately, then patients and families would be directed to the patient advice and liaison service (PALS) to make a formal complaint.

Managers investigated complaints and identified themes. Complaints were monitored on the integrated medicines key performance indicator (KPI) dashboard. For example, the monthly traffic light, (red, amber, green) dashboard for January 2022 had a red rating due to the division having received three complaints in the month.

Staff knew how to acknowledge complaints and patients received feedback from managers after the investigation into their complaint. The patient experience team worked with the complaints team in reviewing patient complaints. Staff told us the main themes from complaints were clinical care; communication and information; and staff attitude.

Managers shared feedback from complaints with staff and learning was used to improve the service. There were weekly divisional patient experience and complaints response tracking meetings. The meetings tracked and monitored divisional complaint responses. Divisional managers, heads of nursing, matrons, the divisional governance team, and a patient relations manager attended the meeting to ensure quality, accuracy and compliance against the trust response target. Once monthly an extended meeting was held to focus on any themes from complaint to update the action log relating to complaints. Learning from the meetings was shared with medical specialty leads.

Is the service well-led?

Requires Improvement 

Our rating of well led stayed the same. We rated it as requires improvement.

Leadership

The trust's senior leaders and some of the divisional leaders were not always visible or approachable to patients and staff.

We viewed a flowchart, (organogram), which clearly detailed the lines of accountability for the division of integrated medicine from ward to board. The divisional structure was led by the divisional triumvirate, comprised of a divisional clinical director, a divisional director of operations and a divisional director of nursing. The divisional clinical director had a deputy.

There were five general managers responsible for 11 specialties, led by specialist clinical leads. The specialties included the department of medicine for older people (DMOP), neurology, cardiology, dermatology, integrated sexual and reproductive health, infectious diseases, respiratory, rheumatology, nephrology, endocrinology and diabetes, who reported into the divisional director of operations.

Medical care (including older people's care)

There were two site-based heads of nursing (one dedicated to Ealing and Central Middlesex Hospital) who reported into the divisional director of nursing, with specialty-based matrons who reported into the Ealing and Central Middlesex Hospital head of nursing.

Some staff told us the trust's senior executive team were not visible at Ealing hospital, as they were based at Northwick Park Hospital. This was similar to what we found at our last inspection. However, staff in the catheterization labs told us senior managers had been very visible during the refurbishment of the unit. Other staff reported a lack of visibility from the trust's leadership team at Ealing Hospital, citing a lack of senior executive walk rounds as an example. We also noted that during an incident on the acute medical unit (AMU) the matron could not attend the ward to support staff in-person and to manage the incident, as they were based at Northwick Park Hospital. A matron from another ward attended the AMU. But this meant the matron had to leave their area of responsibility to address issues on the AMU. Staff told us the AMU matron was very supportive and could be contacted by telephone or email.

The Macmillan trust lead nurse for cancer and palliative care covered cancer, haematology, end of life care and palliative care. They were supported by an 8c senior nurse for palliative and end of life care.

The trust's executive lead for safeguarding was the chief nurse who chaired the quarterly integrated safeguarding board (ISB) meetings. The deputy chief nurse provided oversight for the trust's strategic safeguarding work.

Vision and Strategy

The service had a vision for what it wanted to achieve and a strategy to turn it into action, developed with all relevant stakeholders. The vision and strategy were focused on sustainability of services and aligned to local plans within the wider health economy. Leaders and staff understood and knew how to apply them and monitor progress.

The trust's 'vision and values' were visible across all wards and departments. The values were 'HEART', this was an acronym of 'honesty, equality, accountability, respect, teamwork'. Managers told us the values had been developed with the trust's staff. Some staff we spoke with were able to articulate the trust's values.

Staff told us there was a lack of interagency working and initiatives operated in conjunction with local providers of mental health services. This meant there was a lack of initiatives to enable the hospital to maintain the flow of patients with mental health needs by collaborative admission and discharge strategies.

We reviewed the trust's clinical strategy 2018-2023 which mentioned cancer services as part of the trust's overall clinical strategy. The trust's cancer services worked to national targets on cancer waiting times and locally delivering on the 'NHS Long Term Plan'. However, the strategy mentioned working with external cancer strategies. We were told that the trust saw 1/10th of London's cancel referrals and was the fourth largest provider of cancer services in London. Due to the size of cancer care, staff told us they felt a separate cancer strategy was required for their local population. Staff said a local cancer strategy would enable cancer services at the trust to set out the trust's ambitions and commitments to improve cancer outcomes for the local population of patients receiving cancer services at the trust.

The trust's integrated safeguarding board (ISB) provided strategic leadership and oversight of safeguarding work and activity across the trust, supported by the safeguarding children committee (SCC) and safeguarding adult committee (SAC). The ISB supported the implementation of the trust's safeguarding strategic work plan 2020 -2023. The work plan aimed to ensure there was sustained progress in meeting the trust's safeguarding objectives of delivering quality care, developing an intelligent data set, promoting a learning culture and early help to prevent abuse.

Managers told us integrated medicines were working on a strategy for remodelling staffing.

Culture

Staff felt respected, supported and valued. They were focused on the needs of patients receiving care. The service promoted equality and diversity in daily work and provided opportunities for career development. The service had an open culture where patients, their families and staff could raise concerns without fear.

The service had virtual staff forums. The trust had introduced a 'civility' programme to encourage appropriate behaviour towards colleagues. Staff told us there were supportive working relationships at Ealing Hospital between medical and nursing staff. Some staff described the hospital as being "like a family."

Staff told us the service was encouraging a 'no blame' culture regarding the reporting of incidents.

'Freedom to speak up' is an initiative encouraging a positive culture where people feel they can speak up and their voices will be heard. The division had designated 'Freedom to speak up' champions, which included both nursing and medical staff.

The management team had conducted staff listening events. Managers told us they had found these events useful in terms of hearing staff feedback and concerns.

The trust had a workforce race equality standards (WRES) improvement action plan 2021/2022. This included fairer recruitment processes including black and minority ethnic (BAME) employees sitting on recruitment panels and managers justifying non-selection of BAME for impact.

The trust workforce race equality standards (WRES) improvement action plan 2021/2022 reported that trustwide 99% of staff had completed equality and diversity training.

The trust workforce race equality standards (WRES) improvement action plan 2021/2022 reported 24% of white staff and 22% of BAME staff reported experiencing bullying and harassment from colleagues.

17% of all staff of all ethnicities reported experiencing bullying and harassment from managers. In response the trust had implemented an action plan to address concerns, including implementation of a comprehensive bullying and harassment plan linked to the trust's HEART behavioural framework. The timelines for this plan to be completed was April 2022. The plan included: reviewing the trust's bullying and harassment toolkit and continuing to embed the HEART bullying and harassment tool; encouraging staff to challenge poor behaviours from colleagues.

Governance

Leaders operated effective governance processes, throughout the service and with partner organisations. Staff at all levels were clear about their roles and accountabilities and had regular opportunities to meet, discuss and learn from the performance of the service.

The integrated medicines division identified a trustwide risk relating to insufficient capacity to manage governance risks post the COVID-19 pandemic. To mitigate the risk the trust had a plan to redeploy a band 8a nurse to review incidents, and two band 6 nurses to review 72-hour reports. At the time of inspection, the governance risk had been reviewed at the quality and risk meeting on 21 February 2022 and the division were awaiting finance approval.

The division had a documented clinical governance framework. This clearly identified the divisions governance meetings and their remit. The framework highlighted that there were six regularly scheduled meetings, as well as the frequency of each governance meeting. There were two meetings which underpinned the six regularly scheduled governance meetings. These were the divisional quality and risk group and the divisional management board meeting.

The divisional management board meeting met monthly to oversee and report on operational business, finance performance and strategic objectives within the Division. These meetings were attended by clinical leads, general managers and the heads of nursing. The meetings maintained an action log and was accountable to the trust's operational management group (OMG).

The divisional quality and risk group met monthly and had overarching responsibility for clinical governance. The group maintained oversight of the governance, quality, safety and patient experience activities of the division's specialty departments and groups. We reviewed four sets of minutes from the group dated 29 September 2022, 27 October 2022, 24 November 2022 and 26 January 2022. The minutes recorded that the group had reviewed reports on incidents, reviewed risks on the divisional risk register, and monitored departmental KPI. The meetings had been attended by representatives from the division's medical, nursing and management teams of each specialty, along with the division's leadership triumvirate and governance leads.

There were also monthly divisional nursing KPI and quality matrix meetings: This was a forum for members of the nursing team to review their individual ward and specialty KPI, and to communicate and raise any issues for discussion.

Specialty clinical governance meetings were held on a regular cycle, supplemented by meetings agreed by the divisional quality and risk group. Each medical specialty had responsibility for overseeing and maintaining appropriate governance over their clinical activity, in accordance with national and trust standards of care, safety, quality and patient experience. Each specialty maintained a specialty risk register. Meetings consisted of representatives from the specialty management and clinical teams.

There were daily safety huddles, these were forums to discuss issues to enable planning for the current working day and to raise any urgent issues. Meetings were attended by representatives of both medical and nursing staff. Wards completed the ward communication tool every morning at 7.30am handovers and used the information gathered to feedback to the daily divisional safety huddle at 8.15am; where incidents overnight and divisional staffing issues were discussed.

There were weekly divisional team meetings which were attended by divisional support teams (HR and finance) and heads of nursing. The meetings were weekly forum where key operational, divisional business and trust performance and operations issues were communicated and discussed.

The trust's mortality and morbidity meetings were discussed at the divisional governance meeting. Mortality and morbidity reviews were presented at the divisional meetings by the head of clinical effectiveness. The meetings included learning from mortality and morbidity reviews. We reviewed Hospital Standardised Mortality Ratio (HSMR) data for the twelve months ending June 2021. The trust's HSMR for the period was 90.3. This standardised score was in the "better than expected" range.

Management of risk, issues and performance

Leaders and teams used systems to manage performance effectively. They identified and escalated relevant risks and issues and identified actions to reduce their impact. They had plans to cope with unexpected events. Staff contributed to decision-making to help avoid financial pressures compromising the quality of care.

Medical care (including older people's care)

The trust used traffic light (red, amber, green) rated key performance indicator (KPI) dashboards to monitor quality and performance. Monthly reports were produced and monitored by senior managers. The dashboards covered essential areas of quality and safety, such as: NHS safety thermometer, this is a measurement tool for improvement in health care, which focuses on the most common harms to patients; patient experience; and workforce and safer staffing. The dashboards enabled senior staff and the board to have a quick visual understanding of the division's performance.

The division used a risk register for identifying, recording and managing risks and actions taken to mitigate risks. The risk register was RAG rated. We noted that the risk register spreadsheet CQC were provided with did not have a filter to enable specific hospital site-based risks to be easily identified, such as Ealing Hospital, Central Middlesex Hospital or Northwick Park Hospital. Risks on the register were dated and reviewed regularly until they were resolved and removed from the register. However, we noted a risk some managers had said was on their worry list, which was not identified on the risk register, this was a risk relating to junior doctors' accountability for patients' tests.

The integrated medicines division had regular board meeting with structured agendas. The meetings discussed 72-hour reports, (these are reviews of serious incidents).

The integrated medicines division had processes to monitor patient discharges. This included weekly divisional flow meetings which discussed reasons for unsuccessful planned discharges; plans for new discharges were also discussed at the meeting. Key findings and trends in patient discharges were shared at divisional management board meetings, the improving flow group, and the inpatient standards group.

All wards had quality boards which were linked to the CQC key lines of enquiry (KLOE) of safe, effective, caring, responsive and well led. The boards had information for patients, visitors and staff on the wards performance regarding the trust's key performance indicators (KPI). This demonstrated openness from the trust regarding the performance of wards and departments. For example, the quality board on the catheterization lab had the KPI dashboard, which demonstrated 100% compliance with the trust's KPI in January 2022. The dashboard displayed in endoscopy demonstrated continuous compliance with the trust's KPI in the 12 months prior to February 2022, except for staff sickness. This was consistently 'red' rated on the dashboard's traffic light, (red, amber, green, (RAG)), system. This meant endoscopy were not meeting the trust's KPI for staff sickness in any month from February 2021 to January 2022.

The trust had moved from a paper-based system of quality assurance audits to an electronic application (app) to monitor quality and performance at ward level. A new app had been introduced the app in October 2021. A quarterly report was produced from the information ward staff input into the app. The first report from the app covered the period October 2021 to December 2021. The second report was in progress at the time of the inspection.

Staff received training in equality and diversity. At the time of inspection 97.4% of nursing staff had up to date training and 90.3% of medical staff.

Information Management

The service collected reliable data and analysed it. Staff could find the data they needed, in easily accessible formats, to understand performance, make decisions and improvements. The information systems were integrated and secure. Data or notifications were consistently submitted to external organisations as required.

The service had a patient data management system.

Managers told us cancer services had built a digital system to track patients across North West London. The system would align the trust's cancer services with other providers in the integrated care system (ICS). The system had been rolled it out in breast cancer care, but services were in the middle of the digital change. The digital alignment meant patients care and treatment could be tracked wherever they received it. The system was due to be rolled out in other cancer services in April 2022.

Staff told us the trust had invested in a new digital patient record system, but staff were unsure of the timelines for the roll out. The system would align patient records with other trust's across North West London. However, some staff told us the trust had too many IT systems and thought they could be streamlined. Staff told us the trust's current IT systems required staff doing double entries across different IT systems and this consumed staff time.

Staff told us there was a trustwide risk relating to the way junior doctors worked and accountability for the patients' tests. Staff told us there was a lack of systems in place for lead clinicians to ensure patients tests were reviewed promptly. Staff said this was as a result of junior doctors not working every day. Staff told us IT systems did not have checks and balances and concerns could be missed as they were not always picked up in a timely way if a junior doctor was not working the following day.

The service had invested in a new electronic patient record. This used the same platform as other trusts in North West London and had the same electronic patient record system. Managers told us the system would be rolled out in 18 months. The digital improvement team were mapping the systems processes at the time of inspection.

Engagement

Leaders and staff actively and openly engaged with patients, staff, equality groups, the public and local organisations to plan and manage services. They collaborated with partner organisations to help improve services for patients.

The trust had recently recruited a band 8 head of patient experience in October 2021. The role was to engage with patients, carers and families, taking a proactive role in improving patient experience and reducing health inequalities. This included embedding NHS Improvement's 'patient experience improvement framework', which included national staff surveys and the Friends and Family Test (FFT), throughout the trust's processes to ensure learning from patient experience.

Managers highlighted that the COVID-19 pandemic meant there had not been opportunities for public or patients engagement meetings due to issues of infection control. However, the trust had introduced a monthly patient and carer consultation group in September 2021. The group was chaired by the patient experience panel. The group had patient representation and Healthwatch representatives.

The trust's response to the pandemic necessitated the redeployment of staff throughout the trust to enable it to adapt to the COVID-19 pandemic. Some managers told us the hospital needed to return to "normal working" following the COVID-19 pandemic. A manager said some staff were in a general malaise due to the disruption caused by the COVID-19 pandemic.

Ealing Hospital held a fortnightly cabinet meeting for middle and senior clinical and operational teams in response to the COVID-19 pandemic. This was initially established to help staff navigate the divisional response. However, managers told us the meeting had evolved into a forum covering announcements, recovery, taking the temperature of the hospital, site developments and work in progress or planned. The meeting was an open forum to share discuss and resolve and issues with healthy attendance for patients, staff and visitors.

The division had bi-monthly meetings with mental health services, that were led by the deputy chief nurse. There were also monthly meetings with the trust's community teams and local authority social care to discuss the interface between acute services and community services. The division also met with representatives from the clinical commissioning group (CCG). For example, the CCG managing director had a tour of the wards in December 2021.

Learning, continuous improvement and innovation

All staff were committed to continually learning and improving services. They had a good understanding of quality improvement methods and the skills to use them. Leaders encouraged innovation and participation in research.

The service had a business case to expand the intensive therapy unit (ITU).

The trust maintained its chemotherapy services throughout the COVID-19 pandemic. Pharmacy introduced a drive through pharmacy service in response to the COVID-19 pandemic to ensure chemotherapy services were maintained. The trust also changed some patients' cancer care from intravenous (IV) therapy to oral therapy to facilitate the continuation of their care and treatment.

Acute oncology services (AOS) were working on a 'vague symptoms pathway'. The senior AOS lead and a GP were leading the project. The project was to review patients with symptoms which may indicate early onset cancers. The project was a work in progress at the time of inspection, with the intention that it would be developed into a new two week wait pathway.

The division were involved in a pilot trial to improve the SSKIN care and comfort chart. SSKIN is a five step (surface, skin inspection, kinetics/keep moving, incontinence/moisture, nutrition/hydration) pressure ulcer prevention care bundle. The new tool was in the process of being reviewed for use by the trust.